Medical Economics



Group or Individual?



High Limits or Low?

Foreign or Domestic?



The long and short of Bentyl's relief of nervous gut

Clinicians 1,2 prove Bentyl is long on effective relief ... short on unwanted side effects including blurred vision and dry mouth.

1 . Heffardy and Browner Son. Hed. J. 45:1139, 1982. 2. Lorbor and Show: Pod. Proc. 12:00, 1942.

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BENTYL

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RX INFORMATION

BENTYL

Bentyl affords direct (musculotropic) and indirect (neurotropic) spasmolytic action. Bentyl provides complete and comfortable relief in smooth muscle spasm; particularly in tunctional G.I. disorders, in irritable colon, pylorospasm, biliary tract dysfunction and spastic constipation.

Composition: Each capsule or teaspoonful (5 cc.) contains 10 mg. at Bentyl (dicyclamine hydrochloride). Bentyl with Phenobarbital

adds 15 mg. of phenobarbital to the preceding formula.

Dosage: Adults - 2 capsules or 2 teaspoonfuls of syrup, three times daily, before or after meals. If necessary, repeat dose at bedtime. In Infant Colic - 1/2 to 1 teaspoonful, ten to tifteen minutes before feeding.

Supplied: Bentyl-In bottles of 100 and 500 blue capsules. and Bentyl Syrup in pint and gallon bottles. Bentyl with Phenobarbital - In bottles of 100 and 500 blue-and-white capsules, and Bentyl Syrup in pint and gallon bottles.

PIONEER IN MEDICINE FOR OVER 125 YEARS

THE WM. S. MERRELL COMPANY St. Thomas, Ontario New York . CINCINNATI

Medical Economics

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Things I've Learned About Investing Here's a collection of investment hints from a former securities analyst who's now an M.D. His views on the stock market are original and stimulating, if not always orthodox	97
Closed-Panel Plans Are Hard to Beat in Court	103
In fact, as Southern California physicians found out re- cently, the courts aren't always the best places to try	
An Eyewitness Report on Soviet Doctors	108
Who Should Own Your Life Insurance Policy? .	124
The answer may surprise you. In many cases it's better, for tax purposes, to have someone else as the legal owner	
Medical Man in the Moon	128
Here's a doctor who spends his spare time at a telescope; his unusual hobby has made him an authority on lunar lore	
Who Should Control Practice in Hospitals?	131
That's the question now before the Iowa courts. If doctors in that state win their fight to run hospital X-ray and laboratory services, they'll set a precedent	
Competition in Medical Practice Today	137
This four-year study of a typical American community shows that professional rivalry, when carried to excess, isn't just a knife in the back; it's hara-kiri	
How Doctors Can Cope With Criticism	140
'Let's not criticize people for criticizing us,' says the in- coming president of the A.M.A. In this article he tells what complaints from the rubble have taught him.	

MORE ▶

CONTENTS (Cont.)

Away From It All: A medical man's vacation—its glowing promise and its harsh realities—as seen by cartoonist Al Kaufman	144
Who Owes the Doctor After an Auto Accident?	146
These eight examples indicate when you can, and cannot, expect an insurance company to foot the medical bill	
Your Best Buy in Malpractice Insurance	156
This panoramic view of the malpractice market suggests that premium rates aren't the only thing to think about. Consider also the screening of risks, the prevention of claims, the fighting of suits, the limits of coverage, the type of contract, and the type of carrier	
Blue Shield Faces Its Hour of Decision	197
Will it move forward from now on? Or backward? It can't stand still Here are the challenges that confront it today, according to this former Blue Shield official	
The Abortion Racket	227
This thought-provoking article asks whether the present abortion laws, always interpreted so narrowly, should re- main on the books. The author's answer: "They should not"	
'I Dispense-and I'm Proud of It!'	243
A doctor damns druggists who (at the patient's expense) want to abolish physician-dispensing	
How to Talk With Patients	253
The sure way to build good will, this M.D. learned, is to approach the patient on his terms, rather than on yours	
DEPARTMENTS	
Panorama	4
Letters	45
Editorials	83
Memo From the Publisher	304

PANORAMA INDEX

Congress Weighs Social Security		William Alan Richardson
For Dentists	4	R. Cragin Lewis
Hoover Report Reaction	4	COPY EDITOR: Donald M. Berwick
Blue Shield-Blue Cross to Expand		MANAGING EDITOR: Mauri Edwards
Coverage	4	CONTRIBUTING EDITOR: Henry A. Davidson, M.D.
How Old Are U.S. Doctors?	5	ASSOCIATE EDITORS: Lawrence C. Goldsmith Albert Meisel
A.C.S. Lets Case Rest Against Fee Splits	6	Thomas J. Owens Edwin N. Perrin
Hawaiian M.D.s Set Up New		ADMINISTRATIVE EDITOR: Lois R. Chevalier
Insurance Plan	7	Annette Amols
Layman Defends Fees	8	Marguerite Hecking Lois Hoffman
Veterinarians on Tap	8	EDITORIAL CONTRIBUTORS: Claron Oakley Jack Pickering
Mass Screening Hit	9	ART DIRECTOR: Joseph Coleman
New Legion-M.D. Dispute	9	PUBLISHER: Lansing Chapman
Giant Fee Survey	10	GENERAL MANAGER: W. L. Chapman Jr.
Doctor-Nurse Friction Is Said to		SALES MANAGER: Robert M. Smith
Harm Patient	12	PRODUCTION MANAGER:

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EDITOR-IN-CHIEF: H. Sheridan Baketel, M.D.

Panorama New insurance plan in Ha-

waii • Veterinarians mobilized for atomic attack • Medical society shuns mass screening • Another Legion-M.D. hassle • Doctor-nurse friction called harmful to patients

Congress Weighs Social Security for Dentists

Medicine's turn may still come, but current efforts to broaden the Social Security program seem to be directed toward the dentists.

As this issue went to press, bills calling for coverage of dentists were before both houses of Congress. They appeared to have a good chance of passing, too—despite the American Dental Association's continued opposition.

One thing that gave impetus to the legislation was the fact that the rank and file of dentists evidently were for it. In fact, Senator Styles Bridges (R., N.H.), sponsor of one of the bills, claimed that in some states, dental sentiment ran 8 to 1 in favor of the extension.

Hoover Report Reaction

As might have been expected, the Hoover Commission proposals on veterans' benefits drew fire from both vets and physicians.

The American Legion's National Rehabilitation Commission adopted a unanimous resolution expressing "shock, disappointment and disapproval of these unfounded, uneconomic and heartless recommendations."

The A.M.A. didn't think the commission went far enough. General Manager George F. Lull voiced particular disappointment over its failure to adopt such of its task force proposals as the one calling for a three-year cut-off of medical care for all non-service-connected cases.

Blue Shield-Blue Cross To Expand Coverage

It looks as though Blue Cross and Blue Shield are finally about to jump into the major medical expense insurance field with both feet. They've approved a set of proposals to guide member-plans that have hesitated to offer "catastrophic" coverage.

Affiliated plans can adopt, reject, or modify these proposals as they please. But since many have long been itching to get their share of the major medical expense insurance business, widespread acceptance is predicted.

The main recommendations:

The list of illnesses eligible for coverage should be enlarged. (It's up to the individual plan to decide exactly what additional illnesses it will insure.)

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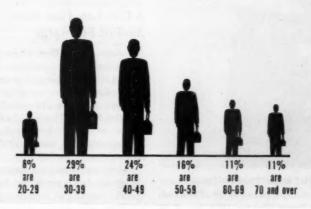
There should be no ceiling on

the dollar benefits payable for any one illness. Such benefits should extend for a period of up to two years.

Any extension of Blue Shield benefits should continue on a service basis in all areas and for all income groups where basic benefits are now offered on that basis.

There should be coverage for the major portion of the cost of chronic and convalescent care. MORE

How Old Are U.S. Doctors?



The above chart shows the percentage of U.S. physicians in active practice at various age intervals. All percentages have been rounded off to the nearest whole figure. Source: A report made in 1955 by the Health Resources Advisory Committee of the Office of Defense Mobilization.



STANDOUT M.D.: When the Junior Chamber of Commerce picked its list of Ten Outstanding Young Men for 1954, one of its choices—the only physician included—was Dr. William A. Spencer, 32, of Houston, Tex. The reason: His outstanding work as director of the Southwestern Poliomyelitis Respiratory Center—a pioneer service he himself founded when he was only 27.

¶ Coverage for mental disturbances, chronic alcoholism, and drug addiction should be offered when no free public facilities for such care are available to subscribers.

¶ Post-hospital medical care should be covered for medical services in excess of \$50, in accordance with an authorized fee schedule.

¶ Emergency treatment for an accidental injury not requiring hospital care should be covered if not included in the local plan's basic contract.

It's estimated that in most states, such added protection would cost individuals an extra 75 cents to \$1.25 and families an additional \$2 to \$3 a month.

A.C.S. Lets Case Rest Against Fee Splits

The American College of Surgeons has called off its publicity drive against unethical surgical practices. Why? Because the campaign has achieved its "first objective," says Director Paul R. Hawley. The conscience of the medical profession, he explains, has been sufficiently aroused.

"More and more local surgical societies are being organized for the specific purpose of eradicating evil practices; and more and more hospital staffs are taking positive action to rid themselves of violators of ethics," he says. Meanwhile, the campaign has "solidified those elements in the profession which desire the unrestricted perpetuation of ... fee splitting and ghost surgery.
[So] now we know where the opposition is."

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Does suspending the publicity campaign mean that the college will be less vigilant in the future? Not at all, says Dr. Hawley; the job of curbing abuses will simply be carried on at the local level. If it lags, then the college will "consider reviving" the publicity.

Hawaiian M.D.s Set Up New Insurance Plan

Hawaiian physicians have now gone further than their colleagues almost anywhere else in providing their patients with a liberal medical care insurance plan.

Under their newly approved program (to be administered through local Blue Shield), most subscribers will have close to 100 per cent protection against both doctor and hospital bills. Only in maternity and tonsillectomy cases will they have to pay a small balance out-of-pocket to the hospital.

The plan's big attraction is an unusually high income ceiling for coverage on a service basis (\$10,000 for a family; \$7,500 for an individual). Its other features include:

¶ Provision for up to 120 days of hospital care for each injury or illness.

¶ Liberal allowances for diagnostic-X-ray and laboratory service, both in the hospital and in the doctor's office.

[MORE]

Snapshots

MENTAL PATIENTS now take up more than half the hospital beds in this country, reports the Hoover Commission. It estimates that existing facilities will be further strained by an additional 250,000 such patients this year.

FREE CARE: Somebody, somewhere in New Hampshire, gets \$4 worth of free medical treatment every minute of the day, shows a survey run by the state medical society. Estimated weekly value of such services: \$40,320.

PATHOLOGISTS REVOLT: Anxious to get direct payment for the work they do, members of the College of American Pathologists have demanded that all hospital pathological procedures be transferred from Blue Cross to Blue Shield.

THE AVERAGE PHYSICIAN who puts in a 60-hour work week spends at least 10 hours a week just keeping up his education, an A.M.A. survey shows.

DOG TAGS for pregnant women, listing blood group, expected date of delivery, and other medical data, have been suggested by Dr. Richard Torpin of Augusta, Ga.



KINSLEY MC WHORTER IR. From a layman, a defense of fees

Subscribers will also be eligible for such special services as annual physical examinations and immunization shots at discount rates.

One reason given for the plan's liberal provisions: the threat of closed-panel competition. Henry J. Kaiser has for some time been investigating the possibility of setting up shop in Hawaii.

Layman Defends Fees

Doctors' fees are not too high, maintains Kinsley McWhorter Jr. of Roanoke, Va. McWhorter is no physician, either, but an editorial writer. Here (condensed) is his argument for the defense, as it appeared in a recent issue of Roanoke's World-News:

"Two young men of equal talent graduate from college at 22. One is an engineer and starts out at a good salary. The second turns to medical school (four years) and interning and specializing (four years).

"By the time both are 30, the engineer has earned \$40,000 to \$60,-000, while the medical student has spent \$16,000 to get more education. So they may be as much as \$75,000 apart.

"If the medical man then begins to earn excellent money, it's only fair. No other practitioner of any art or science spends so much time in study. No other has to spend so much money. No other gives of himself so freely.

"Try calling a plumber or a TV repairman. Pretty big bill, isn't it? Should your doctor get less?"

Veterinarians on Tap

In the event of atomic attack, veterinarians will be mobilized to help physicians in the treatment of human casualties, announces the Civil Defense Administration. It asks that veterinarians prepare themselves now for such an emergency. Firstaid courses are being set up to give them this preparation.

If H- or A-bombs fall, the veterinarians will work under the supervision of physicians at civil defense first-aid stations. Among their probable duties: to help treat shock, burns, and surgical casualties; to splint fractures; to administer blood transfusions and medications; to perform venipunctures; and to assist generally in the care of radiation casualties.

Mass Screening Hit

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Latest to turn thumbs down on multiphasic screening is the Michigan State Medical Society. It says it will have nothing more to do with such tests because:

 They establish "the questionable concept that the discovery and diagnosis of all disease is a public health responsibility"; and

They discourage "the regular, thorough physical examination in the doctor's office by promoting a false idea that a hasty screening program at infrequent intervals is a proper substitute."

New Legion-M.D. Dispute

Once again, recently, organized medicine and the American Legion locked horns. This time, in Indiana. And this time, not over veterans' care but over the regulation of hospital staff membership.

The specific issue: a bill in the state legislature, requiring hospitals that receive public funds or tax exemptions to open their staffs to any graduate of an accredited medical school who may apply for membership.

The measure had the strong support of the Legion (which just last year passed a resolution calling on

Snapshots

OFF TO EUROPE? Then make sure you've got all your hotel and travel reservations before you go, or you may have trouble getting them once you're there. Travel agents report that the American invasion of Europe will be even bigger this year than last—and 1954 hit a record.

HOW'S THAT AGAIN? The following ad appeared recently in the Situations Wanted—Female column of The Marion (Ind.) Chronicle: "PRACTICAL NURSE. Will relieve you part time. Phone—."

SPOTLIGHT ON G.P.s: Paul de Kruif's February Reader's Digest article, "Family Doctor: Model 1955," reportedly brought in 500 inquiries a day from people who wanted to know how to go about getting a family physician.

DEDUCTION BARRED: The cost of travel "for the purpose of seeking spiritual help to alleviate a physical defect" is not a legitimate medical deduction. So ruled the U.S. Tax Court in the case of a man who had sought such a deduction for the expense of a trip taken by his ailing daughter to the shrine of Our Lady of Lourdes, in France.

PANORAMA

all its state organizations to press for such action). It had the equally strong opposition of the state medical society and hospital association (which, of course, maintained that the requirements for staff membership are the concern of each individual hospital).

In what may be the first of a rash of such attempts in various states, the doctors and hospital administrators won out easily. The bill was defeated in committee and never even reached the floor of the legislature.

But why, it was asked, is the Legion so intent on pushing for open hospitals? Legion officials would say only that every American has the right to choose his own physician when hospitalized and that this is impossible as long as there are qualified doctors who lack access to hospitals.

One Hoosier M.D., who thought he knew the real reason for "this latest nuisance," said, "It's as plain as the nose on your face: The Legion simply wants to get back at doctors for their 'uncooperative' attitude in the matter of care for non-serviceconnected cases."

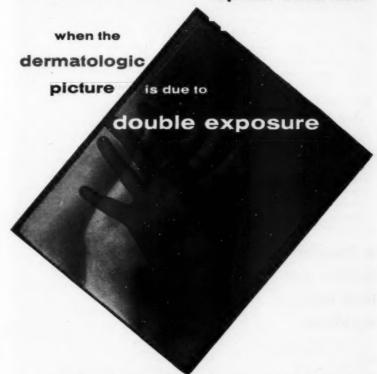
Giant Fee Survey

When the New York County medical society voted recently for a boost in income ceiling for Blue Shield service benefits (from \$4,000 to \$6,000), it urged a boost in fee schedules too.

United Medical Service (the New

more potent than cortisone or hydrocortisone - devoid of major undesirable side eff

Terra-Cortril topical ointment



Terra-Cortril Topical Ointment rapidly clears both underlying inflammation and superimposed infection, through the combined actions of Cortril. — most potent anti-inflammatory adrenocortical steroid, and Terramycin — "perhaps the most effective antibiotic in pyogenic skin diseases." supplied: In 1/2-oz. tubes containing 3% Terramycin (oxytetracycline hydrochloride) and 1% Cortril (hydrocortisone, free alcohol) in a specially formulated, easily applied

Rukes, J. M., et al.: Metabolism 3:481, 1954.
 Peterkin, G. A. G.: Brit. M. J. 1:522, 1954.

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ointment base. also available: CORTRIL Topical Ointment and CORTRIL Tablets.

Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

York Blue Shield plan) agreed. What's more, it decided to make the revised schedule as acceptable as possible to Manhattan physicians:

It's currently polling every one of them (there are 7,000 in the county medical society alone) to see what they think the new rates should be.

Doctor-Nurse Friction Is Said To Harm Patient

Nothing hinders the recovery of a hospitalized patient so much as a charged atmosphere, warns psychologist Ernest Dichter. The patient suffers especially, he says, whenever there's a lack of harmony between the doctor and the nurse. As a dramatic example of how the "quality of the interfamily situation" can help or hinder the sick patient, Dichter, in The Modern Hospital, cites the following experience. It was recounted to him by a man who found himself in a hospital where "the element of conflict between the doctors and nurses was strong":

"A couple of days after my operation—during the night—I noticed a lot of blood flowing through the glass part of the tube they had in me. Somehow that didn't look good to me, so I rang for the nurse. Took her a hell of a long time to get there —busy, I guess—and when she did, she sort of waved her hand and

A Powerful Sedative with three active ingredients

DOSAGE: For insomnia, 1 to 2 teaspoonfuls on retiring. In cases of nervousness, the sedative dose is ½ to 1 teaspoonful repeated up to 3 times daily. Maximum dosage 3 teaspoonfuls per diem.

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STRESSCAPS

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said, 'Oh, that's all right, you're bound to have some of that with this operation.'

"Well, then she left—and I'm not too proud of this, but it shows you what a man will do when he's scared sometimes. I got the feeling that she really didn't know what she was talking about, and that blood was coming thicker and thicker, so I just laid on that bell.

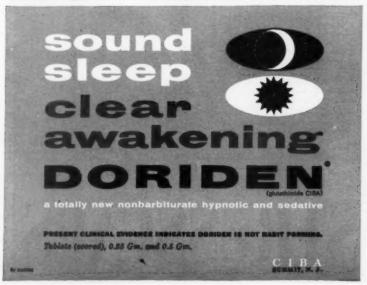
"When she came in she was mad, I could see, and I told her I wanted her to call my doctor, right then. By gosh, she wouldn't do it! She did say she wasn't going to disturb my doctor by calling him in the middle of the night! Well, time went on, nobody came in to see how I was

getting along and I got myself in a stew. I'm ashamed of myself now, but I started yelling my head offl...

"Well, they say the wheel that squeaks the most gets the most grease. Pretty soon things start to happen; and then in walks my doctor, still buttoning up his shirt.

"He took one look at me and the bloody tube, and the next thing I knew I was back in surgery. It appears I was hemorrhaging and they had to open me up again to stop it. After that I was okay.

"I heard later that the doctors do criticize the nurses for calling them unnecessarily. I don't blame the nurses for feeling scared to call, if that's the case."











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Paten

formulas: Available in two dosage strengths: 'Dexamyl' Spansule (No. 1), containing Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 10 mg., and amobarbital, 1 gr.; 'Dexamyl' Spansul: (No. 2), containing 'Dexedrine' Sulfate, 15 mg., and amobarbital, 1½ gr.
Also available: 'Dexamyl' Tablets and Elixir.

16 MEDICAL ECONOMICS - MAY 1955

"Depression and frustration are a daily experience in this man's life ..."

"A single 'Dexamyl' Spansule supports his mood, gives him perspective ..."

patient: A.W., a retired school teacher. "Depression and frustration are a daily experience in this man's life. Married for over forty years, he has had more marital unhappiness than any husband I have known.

"For years I have attempted to bolster his spirits and to enrich his interest in living by sympathetic counsel. psychic suggestion and even philosophic reflection. At times all of these have failed . . . when combat and friction enter by the door, philosophy and decorum fly out by the window."

treatment and response: "I have found 'Dexamyl' to be the answer to this tormented individual's problem. Ordinary sedatives would only depress him . . . he often needed something which would soften the bitterness of the moment, and also lift his mood to make life worth the effort of living. A single 'Dexamyl' Spansule No. 2. taken on arising, supports his mood, gives him perspective . . .

(This photograph was taken during the patient's interview with his physician, a general practitioner. The case report is in the physician's words.)

Dexamyl* Spansule No.1 and No.2

to provide day-long relief from mental and emotional distress—with just one oral dose

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Aeroplast dressing is peeled aff like a glove 12 days after 2nd degree burn.²

Rigler and Adams¹ dressed 110 operative wounds (including thoracotomies, laparotomies, inguinal hernias and miscellaneous lesions) with Aeroplast. "A single application sufficed in all but fifteen cases. No instances of systemic or clear-cut reactions were observed. Satisfactory results, with no evidence of erythema, infection, or necrosis were obtained in the majority of cases."

In 39 miscellaneous wounds dressed with Aeroplast (including appendectomies, open reduction of fractures, skin graft donor sites, lacerations, excoriation), Choy² reports infection in only one case, which promptly cleared with redressing, and uneventful healing in all others.

- Rigler, S. P. and Adams, W. E.: Experience with a new sprayable plastic as a dressing for operative wounds, Surg. 36:792 (Oct.) 1954. (University of Chicago Clinics, Chicago, Surgical Spraice).
- Choy, D. S. J.: Clinical trials of a new plastic dressing for burns and surgical wounds, Arch. Surg. 68:33 (Jan.) 1954. (Believue Hospital, New York, Third Surgical Division—Dr. John Mulholland, Chief).

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Produces objective improvement demonstrable by ECG.

Each tablet of Pentoxylon combines the tranquilizing, stress-relieving, bradycrotic effects of 1 mg. Rauwiloid and the prolonged coronary vasodilating effect of 10 mg. pentaerythritol tetranitrate (PETN). The combination provides a new completeness of treatment previously unavailable to patients with angina. The contained Rauwiloid serves to overcome tachycardia -to permit better coronary filling without increasing cardiac work. This effect, together with the lasting coronary relaxation afforded by PETN, combine to reduce nitroglycerin needs, increase exercise tolerance, reduce anxiety, allay apprehension and produce objective improvement demonstrable by ECG.

Development of full effectiveness of Pentoxylon requires about 2 weeks of therapy, though benefits have been observed after 24 hours.

> Dosage: Initially, 1 tablet q.i.d. Available in bottles of 100 long-acting tablets.

Descriptive literature on request



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BULLETIN

MEATAL STRICTURE

OF THE URETHRA IN INFANTS

ircumcision of newborn babies is now, of course, routine in many hospitals, regardless of the religion of the parents. Justifiable as the procedure may be, it still carries its risks and complications.

• The occurrence of parameatal ulceration, with resulting scarring and contractures, may sometimes cause urinary obstruction and necessitate meatotomy. Unprotected by the foreskin, the sensitive skin of the glans (particularly the parameatal area, which remains wet longest) becomes easily excoriated by rough

diapers, particularly when they have first been wetted and allowed to dry before changing. An original slight irritation leaves the skin more susceptible to further trauma and a small area begins to ooze serum. A scab forms which itself may repeatedly be torn off by sticking to the diapers. Finally, a chronic ulcer results, with scarring which may cause serious narrowing of the meatal opening.

· Fortunately, this condition can always be prevented if detected and treated early. At the first sign of such irritation of the parameatal area, the mother should be instructed to use softer diapers with more frequent changes, or to omit diapers, and to use protecting ointments until the lesion heals.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.





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ing Baby Foods And Heinz Baby Food vertising Are Reviewed And Accepted The Council On Foods And Nutrition.

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N.B. Doctor, you'll like Sanka Coffee, too. It is a choice blend with a flavor and aroma that is completely satisfying.



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in rheumatoid

more effective therapeutic agent than older corticosteroids

Three to five times as potent as oral cortisone or hydrocortisone, milligram per milligram, METICORTEN provides enhanced anti-inflammatory and antirheumatic action without the major undesirable effects associated with older corticosteroids.

Within 24 hours after administration of METICORTEN, joint pain decreases, and stiffness and local heat diminish. Improvement in functional capacity and mobility follows quickly. Lexcellent results are obtained even in patients no longer responding to cortisone or hydrocortisone. Le

And in intractable asthma, METICORTEN controls symptoms rapidly, markedly increases vital capacity, and permits patients to resume normal activities promptly.^{3,4}

Dosage and Administration

METICORTEN is available as 5 mg. scored tablets in bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5 to 20 mg. is reached. The total 24-hour dose should be divided into four parts and administered after meals and at bedtime. Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty.

arthritis

"... free of significant metabolic, water or electrolyte disturbances."

The higher therapeutic ratio of METICORTEN permits marked clinical benefits unaccompanied by many of the major undesirable actions characteristic of cortisone and hydrocortisone. 1-4

METICORTEN

PREDNISONE (metacortandracin)

Schering

- · avoids sodium and water retention
- · avoids weight gain due to edema
- · no excessive potassium depletion
- · better relief of pain, swelling, tenderness; diminishes joint stiffness
- lowers sedimentation rate even where cortisone or hydrocortisone ceases to be effective—"cortisone escape"
- · most effective in smallest dosage

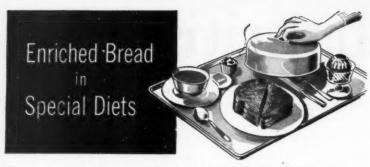
Bibliography

(1) Dordick, J. R., and Gluck, E. J.: Preliminary clinical trials with metacortandracin in rheumatic diseases. Comparative antirheumatic potency, metabolic activity and hormonal properies, J.A.M.A., in press. (2) Bunim, J. J., Pechet, M. M., and Bollet, A. J.: J.A.M.A. 157:311, 1955. (3) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Clinical and physiological studies on the use of metacortandracin in respiratory disease. I. Bronchial asthma, Dis. Chest, in press. (4) Schwartz, E.: Personal communication.

METICORTEN,* brand of prednisone (metacortandracin).
*T.M.

SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY





THE many advantages of enriched bread in special diets are all too seldom recognized or appreciated. Hence the physical, physiologic, nutritional, and dietetic values of enriched bread warrant detailed enumeration.

The open, soft texture of enriched bread enables its easy mastication, its ready absorption of digestive juices, and its prompt and thorough digestion. Reflexly, its appetizing eating qualities enhance the digestive processes. Since bread is free from coarse or harsh vegetable fiber, it proves nonirritating mechanically to the gastric and intestinal mucosa. In metabolism its minerals are neutral.

Enriched bread contains less than 0.2 per cent fibrous material, yielding insignificant amounts of indigestible residue. It contains only 3 per cent of fat, negligible amounts of purines, no cholesterol, and does not interfere with the digestive or absorptive processes. It contributes to a desirable texture of the food mass throughout the intestine. The contained nutrients are absorbed gradually.

Nutritionally, enriched bread supplies valuable amounts of bio-

logically valuable protein, 8.5 per cent; easily digestible carbohydrate, essentially starch and dextrins, 52 per cent: and minerals, 1.8 per cent. Enriched bread provides notable amounts of vitamins and minerals: each 100 grams supplies on the average 0.24 mg, of thiamine, 0.15 mg, of riboflavin, 2.2 mg. of niacin, 88 mg. of calcium, 92 mg. of phosphorus, and 2.6 mg. of iron. Also it provides 275 calories of nutrient energy per 100 grams.

Enriched bread, in either fresh or toasted form, contributes to the eating pleasure of many other nutritious foods. Its neutral flavor permits it to blend well with other foods.

For these many reasons, enriched bread enjoys a prominent place in a great variety of special diets-soft,

low residue, low purine or cholesterol diets, general hospital diets, as well as diets low or high in carbohydrates, in proteins, or in calories.





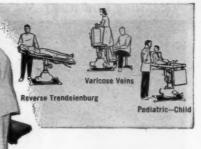
The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN BAKERS ASSOCIATION

20 NORTH WACKER DRIVE . CHICAGO &. ILLINOIS



Horizontal



Have you seen a demonstration of the 12 treatment positions ... EXCLUSIVE with the RITTER UNIVERSAL TABLE?

The supreme flexibility of the Ritter Multilevel Table meets every positioning requirement . . . regardless of patient condition, size or age. This motor-elevated table makes your treatment hours easier, you see more patients with less effort. Your Ritter Dealer representative is qualified to give you a complete demonstration of how the Ritter Universal Table can be of greatest value in your practice. Call him now, or write the Ritter Company, Inc., Ritter Park, Rochester 3, N. Y.

Ritter



Company Inc.

"Gardening hard work? Not when you're in good shape!"



Physical fitness is enjoyed at any age, but during the later years it is especially coveted. Gevral supplies all the vitamins and minerals the older patient may need to continue feeling young at heart.

Gevra1*

Geriatric Vitamin-Mineral Supplement Lederle

EACH GEVRAL CAPSULE CONTAINS:

Vitamin A	5000	U.S	P. Unit
Vitamin D	500	U.S	P. Unit
Vitamin Bra			1 mcgm
Thiamine Mononitrate (B1)			5 mg
Riboflavin (B2)			5 mg
Niacinamide			15 mg
Folie Aeld			1 mg
Pyridoxine HCl (B ₈)			$0.5~\mathrm{mg}$
Ca Pantothenate			5 mg
Choline Dihydrogen Citrate			100 mg
Inositol			50 mg
Ascorbic Acid (C)			50 mg
Vitamin E (as tocopheryl acetat	es)		10 I. U
Rutin			25 mg

Purified Intrinsic Factor	
Concentrate	0.5 mg.
Iron (as FeSO ₄)	10 mg.
Iodine (as KI)	0.5 mg.
Calcium (as CaHPO ₄)	145 mg.
Phosphorus (as CaHPO ₄)	110 mg.
Boron (as Na ₂ B ₄ O ₇ , 10H ₂ O)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF ₂)	0.1 mg.
Manganese (as MnO ₂)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K2SO4)	5 mg.
Zinc (as ZnO)	0.5 mg.

Other Lederle geriatric products include: Gevrabon* Vitamin-Mineral Supplement liquid with a wine flavor; Gevral* Protein Vitamin-Mineral-Protein supplement powder; and Gevrine* Vitamin-Mineral-Hormone capsule.

EG. U.S. PAT. OF



LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York





Which glove works best in surgery?

Please pordon us if we seem facetious, but a surgical glove seems a good illustration of the importance of appropriate design in the manufacture of accessories. Without this glove surgery wouldn't be safe. And only when it serves as intended, by such as permitting complete finger freedom and sensitivity, is it of any value. When so designed it has no equal for its purpose.

(R⁴

DEE.

ork



And so it is with accessories of other kinds. Those for example you need to run your electrocardiograph. The accuracy and usefulness of such a precision instrument is in direct ratio to the effectiveness of its parts and accessories. Of what value is the high deflection speed and top performance of an ECG if the recording paper cannot successfully show it in clear, sharp and distinct registrations? Of what value is an electrode paste which does not reduce patient resistance at electrode connections to a level suitable for modern cardiography?

An accessory designed by the maker of an instrument should receive the same care, study and research as any of the important parts or components of that instrument. This is true in regard to the Viso-Cardiette. Much of the Sanborn Viso-Cardiette's fame as a direct-writing cardiograph can be attributed to the continuous, painstaking research on the two accessories which were originally designed by Sanborn Company, and which are so necessary to the Viso's accuracy — Permapaper (inkless recording paper) and Redux (electrode paste).

Permapaper and Redux are major examples of Sanborn accessories that receive diligent surveillance as to the service they are performing — one more part of the Sanborn policy of complete service to the ECG user.

SANBORN COMPANY

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If you could "take apart" a droplet of KONDREMUL mineral oil emulsion...



...you would find it different because

each microscopic oil globule is encased in a tough, indigestible film of Irish moss for perfect emulsification and complete mixing with the stool. in p

KONDREMUL®PLAIN

COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS

for chronic constipation

highly penetrant...highly demulcent... highly palatable—no danger of oil leakage or interference with absorption of nutrients when taken as directed

THE E.L. PATCH COMPANY STONEHAM, MASSACHUSETTS



in pruritic dermatoses...so little goes so far and lasts so long

EURAX

(brand of cretamiton)

relief in minutes that lasts for hours

Unsurpassed for controlling itch, EURAX Cream and Lotion spread so readily and smoothly that they need be applied only sparingly. Minimal quantities can be prescribed, with appreciable savings to your patients.

Effective in more than 90% of cases, EURAX gives your patients these additional outstanding advantages:

Prompt Relief-A single application gives relief in minutes.

Prolonged Action - Relief usually lasts 6-10 hours.

Greater Safety-No toxic, irritating, or sensitizing properties.

Invisible on the Shin-EURAX is odorless, greaseless, and nonstaining.

EURAX® (brand of crotamiton) Cream and Lotion contain 10 per cent N-ethyl-o-crotonotoluide. Available on prescription only.



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GEIGY PHARMACEUTICALS Division of Goigy Chemical Corporation 220 Church Street, New York 13, N.Y.



Scene in your office?

Complete anorectal examination - digital, anoscopic, sigmoidoscopic - is rapidly becoming a part of every complete physical examination. This is as it should be, for early diagnosis of cancer and precancerous lesions in this area can contribute greatly to raising the present low percentage of cures. Anorectal examination, as thousands of doctors have discovered, is not an involved or mysterious procedure. It is made even easier by the use of uncomplicated, brilliantly illuminated Welch Allyn anoscopes and sigmoidoscopes, for which your regular WA battery handle serves as the power source. Ask your dealer to show you these practical instruments.

> The Welch Allyn booklets "Anal and Lower Rectal Lesions" and "Proctologic Examination" are available from your WA dealer or from Welch Allyn, Inc., Skaneateles Falls, N. Y.

WELCH HALLYN

Easy-to-use Rectal Instruments

for daytime tension

You can now prescribe Noludar

'Roche' -- a new, mild sedativehypnotic which is not a barbiturate. Tests in over 3000

patients have confirmed the
clinical value of Noludar

(3,3-diethyl-5-methyl-2,4piperidinedione).

NOT A BARBITURATE

Noludar Rochz



for daytime tension



and mervous insorunia

NOT A BARBITURATE

The Geriatric Diet strikes a happy balance!

Your elderly patient may cut down his food range to the point where foods high in protein, vitamins, and minerals are virtually eliminated. These suggestions may help you show him how to plan and enjoy a better-balanced diet.

These are essential—

Meat, as always, is important. Fish steaks, chicken parts, or chops can be bought in small portions. And adding skim milk powder to hamburger boosts protein and calcium.

Plenty of fruits and vegetables mean adequate vitamins in proper balance. Strained vegetables and canned fruits are easy to chew. And salads need no cooking.

Be sure the fluid intake is liberal. And it need not necessarily be water.

These are for fun—

Good company and a pretty plate make a happy combination. Or a tray in a sunny window makes all outdoors the guest.

A one-dish casserole gives free rein to the imagination and cuts down dishwashing. But perk up flavor with spices and herbs.

Beverages of moderate alcoholic content before dinner and at bedtime often aid appetite and may induce a better night's sleep.

The number of people over 60 is still on the upswing. And with proper attention to diet, these added years can be far happier both for the elderly and their families.





United States Brewers Foundation

Beer-America's Beverage of Moderation

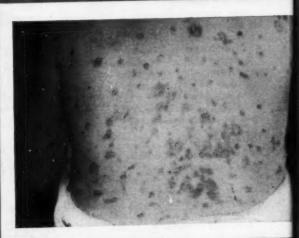
Sodium 17 mg, Calories 104/8 oz. glass*

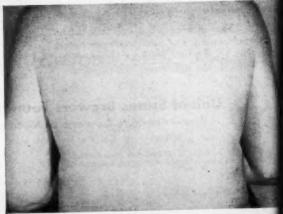
If you'd like reprints of 12 different diets, please write United States Brewers Foundation, 535 Fifth Ave., New York 17, N. Y.

*Average of American beers

After three months of

MAZON dual therap





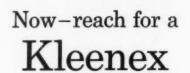
Pure, mild MAZON soap is preferred by many





antipruritic ointment

MAZON



tissue in the pure white professional box

Here's the new professional packing for Kleenex*, the only tissue that pops up, serves just one at a time. It's a pure white box that's designed especially for the use and convenience of physicians. And it's available in an easy-to-store case of 24 boxes. Keep Kleenex handy—for dozens of office uses!

Regular size No. 5101, 9" x 10". Professional size No. 5405, 15" x 18"

Order through your supply dealer



physiologic answer

to "morning sickness"

EMETROL

In a controlled study, Crunden and Davis¹ clearly established the value of EMETROL in nausea and vomiting of pregnancy. EMETROL produced favorable responses in 78.8 per cent of 123 patients, as compared with only 14.8 per cent of 122 patients receiving a placebo of like appearance and taste. Relief was usually secured within the first 24 hours of treatment. EMETROL was found to be a safe, physiologic agent, free of annoying side actions. Containing no drugs likely to induce untoward effects, EMETROL is easy and pleasant to take, safe for all age groups.^{2,3}

DOSAGE: 1 to 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens.

IMPORTANT: EMETROL must always be taken *undiluted*. Fluids should not be allowed for at least 15 minutes after each dose.

SUPPLIED: In bottles of 3 fl.oz. and 16 fl.oz. through all pharmacies.

in epidemic vomiting (acute infectious gastroenteritis, intestinal "flu"), EMETROL works rapidly, even in refractory cases; control is usually established with the first few doses, "often with a single dose."²

Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:511, 1995.
 Beadley, J. E., et al.: J. Pedist. 38:41, 1951. 5. Tebrock, H. E., and Fisher, M. M.: M. Times 82:721, 1994.



Literature and sample on request

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When your geriatric, dyspeptic, underweight, or gallbladder patient doesn't respond to diet, the cause is frequently an inability to utilize food.

CONVERTIN furnishes the dietary catalysts necessary for efficient absorption in these individuals.

The specially layered construction of CONVERTIN provides selective release of ingredients to assure efficient absorption in the stomach and small intestine.

SUPPLIED: In bottles of 84 and 500 tablets.

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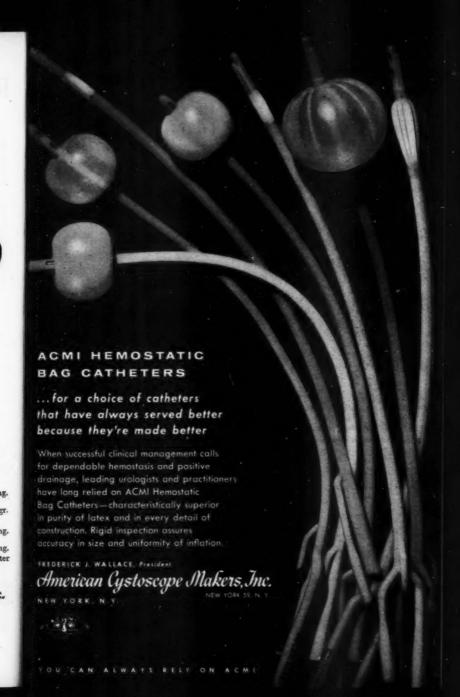
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New Model 250 ELECTROCARDIOGRAPH

Once you have watched a demonstration and operated the Edin 250 Electrocardiograph yourself, you can appreciate how revolutionary this instrument actually is.

IMPORTANT EDIN SPECIFICATIONS

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- Push button selection of calibration, "Off" controls and all leads
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This coupon will bring your LOCAL Edin representative to demonstrate the 250.

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Gentlemen:

Without obligation, I would like to see an Edin Electrocardiograph in operation and receive full information.

Name.

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Position



COMPANY, 1 207 MAIN ST. . WORCESTER, MASS.



Laxative action ... suited to her routine

Relief of temporary constipation:

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Agoral is suited to the acutely constipated patient who can neither take time off for a "purge," nor time-out to answer the sudden urge induced by strong laxatives: the head of a one-man business; the executive committed to a day of important conferences; the bus driver on a long haul; people in the theatre, the pulpit, the factory, the home. For all who need relief of temporary acute constipation, pleasant tasting Agoral provides positive results without urgency.

No urgency; evacuation which adjusts to schedule: A dose taken at bedtime almost invariably produces results the following day. Elimination is comfortably achieved by mild, positive peristaltic action, not by violent paroxysms of unrestrained hyperperistaltis.

No griping; interim discomfort avoided: Agoral's action is sustained uniformly during its passage through the intestinal tract; and it causes no uncomfortable griping, embarrassing flatulence, distention or stomach distress.

Dosage: On retiring, ½ to 1 tablespoonful taken in milk, water, juice or miscible food. Repeat if needed the following morning two hours after eating. Contraindications: symptoms of appendicitis; idiosynerasy to phenolphthalein.

Supplied: bottles of 6, 10 and 16 fluidounces; and as Agoral Plain (without phenolphthalein), bottles of 6 and 16 fluidounces.

Agoral

mineral oil emulsion with phenolphthaleia

WARNER-CHILCOTT

for patients with allergy



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prescribe full enjoyment of springtime

'Co-Pyronil'

The allergic patient can enjoy springtime to the fullest: 'Co-Pyronil' often eliminates distressing symptoms without causing side-effects.

Because 'Co-Pyronil' is unusually long acting, it affords the patient continuous relief without the inconvenience of frequent doses. Also, the bedtime dose keeps the patient symptom-free throughout the night.

Each pulvule provides the complementary effects of:

'Pyronil' (Pyrrobutamine, Lilly) 15 mg.

'Histadyl' (Thenylpyramine, Lilly) 25 mg.

'Clopane Hydrochloride'

(Cyclopentamine Hydrochloride, Lilly) 12.5 mg.

Dose: Usually 1 or 2 pulvules every eight to twelve hours. Increase or decrease as needed.

Also: Suspension CO-PYRONIL

One-half the above formula in each 5-cc. teaspoonful. Deliciously flavored.

Pulvules CO-PYRONIL, Pediatric

Tablets PYRONIL, 15 mg.

ELI LILLY AND COMPANY . INDIANAPOLIS 6, INDIANA, U.S. A:



Are ACTH and cortisone (or hydrocortisone) practically one and the same?

No-There Is A Difference!





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THERE IS A
DIFFERENCE
BETWEEN ACTH
AND CORTISONE

Only the therapeutic effects of ACTH and cortisone are practically alike. However, there is a decisive antagonism between ACTH and cortisone regarding function and tissue structure of the adrenal cortex.

ACTH therapy stimulates the adrenal cortex to produce larger amounts of steroids with a proportionate increase of the secretory tissue to prevent exhaustion.

Cortisone therapy suppresses the production of corticosteroids. This suppression is accompanied by an atrophy of the adrenal cortex with a subsequent complete loss of responsiveness to stress. The patient becomes entirely dependent on the external supply of cortisone or on reactivation of the pituitary-adrenal system by ACTH administration.



HP*ACTHAR Gel is The Armour Laboratories Brand of Purified Adrenocorticotropic Hormone Contientropin (ACTH).



THE ARMOUR LABORATORIES
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Letters

Solving the problem of veterans'

care • Comments on delegating work • Good style in medical writing • Indexing medical literature • Who needs voluntary

coverage? • Says doctors don't make good hospital trustees

Druggist vs. Dispenser

SIRS: Today I read a lot of nonsense in your magazine on the subject of dispensing, called "Druggists Draw-Bead on Dispensing M.D.s." This article seems to give only the druggists' side of the story . . .

The greed of these parasites is matched only by their audacity . . . About 99 per cent of all prescriptions are filled by merely dumping some tablets out of a bottle or by pouring a liquid from one bottle to another. The pharmacist's markup on these products would make an honest grocer blush . . .

> Robert Greaves, M.D. Collinsville, Ill.

Sirs: ... I recently checked twenty prescriptions filled in local drugstores and found that in nine cases the patients got substitutes. In only one instance had the pharmacist asked me to authorize the substitution. I now keep samples of drugs I usually prescribe and show the patients how the medicine is supposed to look . . .

I do practically no dispensing now, but I am seriously thinking about a change in this policy to insure proper treatment.

> I. Ramunis, M.D. Chicago, Ill.

Sirs: . . . In this section of the country, the druggists counter-prescribe drugs plainly labeled, "CAU-TION: Federal law prohibits dispensing without prescription." Some of them have been giving injections, and one (until four months ago) even made house calls . . .

R. F. Dodds, M.D. Brantley, Ala.

If this article represents a declaration of intent on the part of the retail drug industry, then I quite agree that "there's cause for alarm in the worsening relationship between the two professions."

The holier-than-thou attitude assumed by the mouthpiece of the druggists' associations appears downright ridiculous when laid alongside the facts: No other in-

dustry has so brazenly entered into competition with noncompeting business firms. Drugstores sell everything from hardware and garden supplies to sporting goods and wearing apparel. The chain and variety stores have been particularly hard hit by the druggists' overaggressiveness.

Now it is very evidently the intention of the druggists and their organizations to relegate the dispensing medical man to the status of a pariah because he is so presumptuous as to place the welfare of his patients above the monetary well-being of the druggist . . .

> Deane R. Brengle, M.D. Wellington, Kan.

Sirs: I dispense inexpensive drugs at a small profit. This profit is necessary to cover the cost of drugs for those patients who are unable to pay . . . If it's true that the A.M.A. doesn't approve of physicians' dispensing, I wonder just who that organization is working for? I have a feeling that it isn't for the general practitioner.

M.D., Oregon

It is true that the A.M.A. doesn't approve of unnecessary dispensing. The Principles of Medical Ethics state that it's unethical for a doctor to dispense drugs and appliances "unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society . . .

On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources."-ED.

Veterans' Care

Sirs: I have some serious reservations about your recent article, "Who's Right-the A.M.A. or the Legion?"

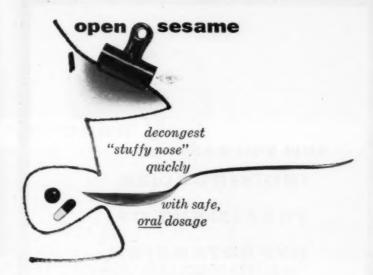
I believe the article is most unfair to the V.A. residency program, which was started by Generals Omar Bradley and Paul Hawley and which was, in my opinion, the greatest contribution to graduate medical education ever initiated anywhere in the world.

I am myself a member of the A.M.A. and of the American Legion, and am associated with the V.A. I know some of the difficulties in the V.A. (also in the two other organizations); but this sort of article will not help solve them. It was written with the implication that most human beings are chiselers or connivers and have to be taken to task belligerently by a few honest scolders.

Karl A. Menninger, M.D. Topeka, Kan.

Delegating Work

Sirs: Your article, "Delegating Work," is excellent. There is only one point I would question, and I think legally I would have some support. MORE



Novahistine®

ELIXIR/TABLETS/FORTIS CAPSULES

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Oral use of this synergistic combination of vasoconstrictor and antihistamine takes the "sting" out of decongestion . . . eliminates risks of improperly used topical agents. And, Novahistine causes no jitters, insomnia, or drug tolerance.

Each Novahistine Tablet, or teaspoonful of Elixir, provides 5.0 mg. phenylephrine hydrochloride and 12.5 mg. prophenpyridamine maleate. In NOVAHISTINE Fortis Capsules the phenylephrine content is doubled, for patients needing greater vasoconstrictive effect.

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INDIVIDUALIZE
TREATMENT OF

SITES OF ACTION

APRESOLINE

SERPASIL® (resemble CIBA)
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Record Book for Physicians

A special rate has been established on the 1955 DAILY LOG during the remainder of the year for doctors just beginning practice. By taking advantage of this "get acquainted" offer, substantial savings can be made in organizing the business side of your practice on a profitable and time-saving basis. The Daily Log is GUARANTEED to supply the most efficient one-volume financial record system for your office . . . or your money back!

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COLWELL PUBLISHING COMPANY 238 University Ave., Champaign 5, Illinois

LETTERS

The author reported that some doctors charge a lower fee for injections and dressings done by an aide than for those they do themselves. I think they're wrong: If the patient is getting the service, the doctor is legally responsible for the quality of that service. Since he can be sued, and sued heavily, for anything the aide does, he should collect on the same basis.

In my office the same fee is charged for an injection, whether it be given by the doctor or by the nurse (unless, of course, the doctor gives advice in addition).

> Charles L. Farrell, M.D. Pawtucket, R.7.

Sirs: I'd like to add one afterthought to my article on delegating work: In the three-girl office, it's a good idea for the secretary to handle receipts. (She's usually at the reception desk, where it's convenient for her to do so.) Thus, since both she and the bookkeeper keep track of cash receipts, you have an automatic check on each girl's efficiency and honesty. Other financial matters-as listed in the table on division of duties-are handled solely by the bookkeeper.

Millard K. Milla Professional Management Waterloo, Iowa

SIRS: Mr. Mills' article is the best and most instructive MEDICAL ECO-NOMICS article I have ever read.

But my curiosity was piqued by his reference to the Cornell Medical t some or injecan aide elves. I patient octor is ality of e sued, ing the on the

fee is ether it by the doctor

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. Mills agement o, Iowa

e best ECOad.

ed by edical



ORTRAIT OF A DELINQUENT APPETITE.

When the clinical picture is composed of a child who "just won't eat" and a mother distraught by nervous worry and despair, prescribe

TROPHITE

to stimulate appetite and promote growth

Each tablet or teaspoonful (5 cc.) of 'Trophite' supplies: 25 mcg. B₁₂, 10 mg. B₁

Smith, Kline & French Laboratories, Philadelphia I



what's cookin?

The tantalizing aromas of a superbly blended cuisine often tempt patients beyond their better judgement. When this occurs, BiSoDoL Mints can provide gratifying relief from gastric distress. BiSoDoL Mints contain Magnesium Trisilicate, Calcium Carbonate and Magnesium Hydroxide to help restore the normal pH of the stomach without either constipation or peristaltic stimulating effect often obtained from other antacids. You can be assured of gratifying results with BiSoDoL Mints.



WHITEHALL PHARMACAL COMPANY . NEW YORK, N. Y.

LETTERS

Index. Would you be kind enough to tell me a little more about this index and how I can obtain it?

> R. E. Brogan, M.D. Billings, Mont.

The Cornell Medical Index is a four-page folder with 195 questions that the patient can answer "Yes" or "No." They're in simple language, understandable to anyone who can read English; and they deal with bodily symptoms, past illnesses, family history, and behavior problems. The two forms of the index-one for men, the other for women-are identical except for six questions in the genitourinary section.

Copies may be obtained from Dr. Albert J. Erdmann Jr., New York Hospital, 525 East 68th Street, New York 21, N.Y. He asks that you specify whether you want those for men or for women. Each type comes in packages of fifty, at \$2.50 per package.

In an early issue, MEDICAL ECO-NOMICS will publish an article describing the Cornell index and similar medical questionnaires in more detail - En.

What's Good Style?

SIRS: "Medical Articles I Never Finish Reading," by Dr. Henry A. Davidson, aroused my dander. Its sum and substance may be sound. But to term an author a "mannered pedant" for choosing aesthetic phrases and to condemn an article



Hemorrhoids needn't hurt

Hemorrhoids need not pain, itch or burn. Inflammation, congestion and pressure can be quickly reduced with Anusol Suppositories.

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red etic cle Prompt, lasting relief of pain and itching: Anusol relieves anorectal discomfort almost immediately upon insertion. Action is soothing and decongestive, Relief is prolonged.

Sufely: Anusol contains no narcotic, analgesic or anesthetic drug. Thus the danger of masking more serious rectal pathology is eliminated.

Easily administered: Anusol is easy to insert. Comfort plus efficacy, especially where prolonged use is necessary, contribute to patient acceptance.

Safe in any situation: Because Anusol does not narcotize, the presence of strangulation, ulceration, malignancy or prostatic disease is not concealed. Diagnosis and treatment of co-existing disorders (anal fissures, infected crypts, polyps, warts, abrasions, abscesses, etc.) are not impeded. Anusol does not produce rectal anesthesia which aggravates concurrent constipation.

night and after each bowel movement. Packaging: Boxes of 6, 12, 24 individually foil wrapped suppositories.

Anusol®

Suppositories

WARNER-CHILCOTT

Edrisal*

S.K.F.'s antidepressant analgesic

For optimum results in dysmenorrhea





tablets per dose

Smith, Kline & French Laboratories, Philadelphia

AT.M. Reg. U.S. Pat. Off.

LETTERS

for good literary style seems a gross injustice. How monotonous it would be to wade through the tons of daily literature were it not for the few that give not only vital information but also superior presentation! . . .

Patricia Lapan, R.N. Hayward, Calif.

Dr. Davidson applied the phrase "mannered pedant" to the doctor who embroiders his writing with Latin words such as "morbilli" and "pes planus" instead of using their straightforward English counterparts. Such writing, in Dr. Davidson's opinion and in ours, is neither aesthetic nor in good literary style. -En

Sirs: . . . Dr. Davidson's own article could have been more concise. It didn't require some 380 lines to make its point.

Incidentally, the pronoun "I" appeared much too frequently (fortythree times), as did "me" and "my" (twelve times).

MEDICAL ECONOMICS is a "must" in my monthly reading, because I know each page represents the work of a large editorial staff. But how did this one slip through?

E. A. Hackie, M.D. Bellflower, Calif.

It seems to us that Dr. Davidson's writing admirably illustrates his point that a lively, personal style is usually best. Certainly his article compares favorably with the gen-

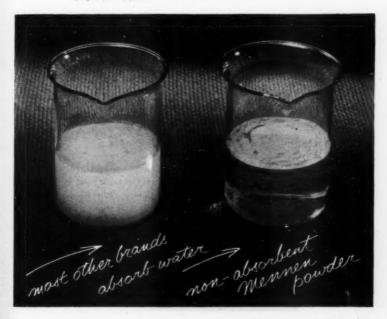
SIMPLE LAB TEST PROVES IT PROTECTS BABIES BETTER

Note the striking difference in water-absorption between Mennen Baby Powder and the other brand! Mennen...the wet-resistant powder, creates a barrier between diaper moisture and baby's skin. And it clings far longer than almost every other brand . . . thus gives better anti-rash protection. The improved formula, which includes the finest Italian talc, results in the superior qualities of Mennen Baby Powder.

MENNEN... BABY SPECIALIST SINCE 1880

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Ulcer protection that lasts all night:

Pamine tablets

Bromide

Each tablet contains:
Methscopolamine bromide

2.5 mg.

Average dosage (ulcer):
One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.
Supplied:
Bottles of 100 and 500 tablets.

The Upjohn Company, Kalamazoo, Michigan



eral run of scientific papers, which are often dull just because they are so impersonal. And we're wondering whether it really was too long, since it's obviously one article that Dr. Hackie did finish reading.—ED.

Scores Deadbeats

SIRS: When will we learn to make our patients pay up promptly?

One day, while visiting a friend in an office building, I saw no fewer than three of my former patients—each of whom owed me more than \$100—enter a young physician's office next door. And since then I've learned that two of them are now going to a third doctor! No doubt they're still charging up bills and then moving on.

If we physicians would only force collections (except in real charity cases), we'd have to do far less work to make a living and to save enough money for retirement. I know whereof I speak: I'm now 78 and still only semi-retired.

Dwight C. Martin, M.D. Lititz, Pa.

Indexing Method

Sins: I feel that my method of indexing medical literature is more comprehensive, more practical, and much simpler than the one recommended in a recent issue of MEDI-CAL ECONOMICS...

As I read, I make a list of the articles that interest me, noting a suitable heading for each. My secretary then transfers these references to the appropriate pages in my loose-leaf encyclopedia of medicine and surgery. At my direction, she also clips summaries from the various medical digest magazines and inserts them between the pages.

Every year, the publishers of the encyclopedia I use send out supplementary pages describing new treatments, etc. If these pages contain any of the references we have already noted, we can of course forget them. Others we transfer from the old page to the new if I feel they may still be useful.

In this way, I keep all the information I need at my fingertips—and in one place.

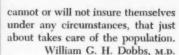
M.D., Tennessee

Voluntary Coverage

Sirs: Your recent article, "Health Bills Caught in Political Wringer," said that about 60 million Americans aren't covered by any form of health insurance and that the Administration wants to give them an incentive to join the voluntary plans. This figure of 60 million was apparently obtained by subtracting the 103 million who do have health insurance from the total population of the United States.

Don't forget that our 20 million veterans and the 5 million persons now in the armed forces are eligible for free medical and hospital care. If to these we add the people on welfare and old-age-assistance rolls, the inmates of penal institutions and state hospitals, and those who either





Torrington, Conn.

It's true, as Dr. Dobbs-and our own article-points out, that many of the 60 million are uninsurable (about half of them, the Administration estimates). But we can't agree that present coverage-plus the groups Dr. Dobbs lists-"just about takes care of the population."

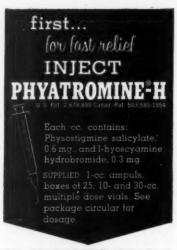
For example, not all 20 million veterans are eligible for free care (though many of them get it anyway). So there's no reason why they can't-and shouldn't-be enrolled in voluntary health plans.-Ed.

M.D.s on Hospital Boards

Sirs: According to a recent news story in your magazine, Dr. Robert F. Brown says doctors "do make good hospital trustees." I think he's overlooked one very important reason why they often don't:

The physician who gets on the board of a hospital may use that position to restrict his own competition. He may see to it that applications from new physicians-in his specialty, at least-are turned down.

In my city, there's an 80-year-old board member who still pushes up to the operating table. For many years no new surgeon has been admitted to the staff. Several have come to the city, only to be starved out. If this required character as-



IN CRIPPLING MUSCLE SPASM . . . as in arthritis, bursitis, myositis, low-back pain, sprains and strains

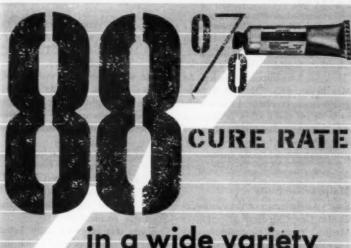
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Salicylamide, 250 mg.;

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OINTMENT

a first choice for dual antibiotic therapy

In a recent study¹ of 53 patients with various types of pyodermas, the use of BACIMYCIN Ointment "...resulted in a cure rate of 88%..." and not a single case of sensitization or primary irritation occurred.

Impetigo, infectious eczematoid dermatitis, atopic eczema, secondary infections superimposed on dermatitis venenata, and folliculitis were among the common skin infections that showed marked improvement with BACIMYCIN therapy.

Supplied in 4-oz. tubes for prescriptions; in 100 gm. jars for hospital use.

Literature and samples on request.

1. Greenhouse, J. M., and Ryle, W. C.: A.M.A. Arch.
Dermat. & Syph. 69:366, Mar., 1954.

Walker LABORATORIES, INC. MOUNT VERNON, NEW YORK

sassination, it was forthcoming . . .

The explanation of how he can get away with this is perhaps contained in James E. Bryan's article, "How Do You Impress People?" As Mr. Bryan says, "the lay trustee generally appreciates his inability to evaluate the quality of medical care." So he takes the word of the doctor he knows best, especially one who's entrenched on the board.

M.D., Massachusetts

Malpractice Suits

Sins: As chairman of the Alameda-Contra Costa Medical Association's Medical Practice Committee, may I say that we physicians in Northern California were pleased to see our "group effort" program described in your excellent article, "And Suddenly Malpractice Suits Tumbled."

One word of caution, though: While we believe the problem of medical malpractice suits is being effectively fought by our program, we cannot share your optimistic view that the number of malpractice suits is dropping *sharply*.

Your article listed a decline in the number of suits filed, from sixtythree in 1950 to nineteen in 1953. These figures are accurate. But I must question your interpretation of them. To illustrate:

Each suit is customarily listed under the policy year in which the alleged malpractice took place, not

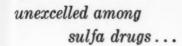
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and for sore throats

specifically designed
to relieve throat soreness
through prolonged direct
contact of aspirin.

White Laboratories, Inc.
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for Highest Potency . Wide Spectrum Highest Blood, Plasma & Tissue Levels Safety.Minimal Side Effects®.Economy

Few therapeutic agents, and none of the other sulfas, can claim the same degree of freedom from toxic side effects offered by the Triple Sulfas. The use of only a fractional dosage of each component sulfa drug reduces the possibility of undesirable side effects to an absolute minimum. No case of agranulocytosis has been reported resulting from their ten. resulting from their use.

Because they are so well tolerated, because of their wide spectrum of effectiveness and their outstanding economy, the Council-accepted Triple Sulfas are now more widely used than any single sulfa drug.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented on their behalf.

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ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS!

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Against streptococci

This is an actual sensitivity test with a strain of Streptococcus pyogenesion a blood again plats. Note the high activity of ERYTHOCIN against this organism. This same streptococcus may be essociated with sinustic... oritis media... housilitis... preumonia... empyema... phoryngitis... septicemia... is reposed... streptococcal tare throat... scarlet fever... serviceta... actain uniney tract infections... and certain cases of subsective horderial endocorditis and osteomyelitis.

Against common intestinal flora

specific therapy against the execi... Now, you can prescribe an antibiotic (Filmtab ERYTHROCIN) that is specific therapy for most bacterial respiratory infections. Specific therapy—because these infections are caused by staph-, strep—or pneumococci. And the cocci are the very organisms most sensitive to ERYTHROCIN. In fact, you'll find ERYTHROCIN more active against this group of organisms than many other antibiotics.

Erythrowen Stearste, Abbott)

Against common intestinal flora

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of E. cali. Note that ERYTHROCIN and penicillin do not affect growth at this organism—while the other antibiotics show marked inhibitory action. Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to cause alteration in common intestinal floro—with an accompanying law incidence of side effects.



...with little risk of serious side effects The main reason is because ERYTHROCIN acts specifically. It destroys only harmful cocic invaders—yet doesn't materially change normal intestinal flora. Thus, your patients rarely get side effects from ERYTHROCIN. Nor do they get the allergic reactions sometimes seen with penicillin therapy. Filmtab ERYTHROCIN (100 and 200 mg.) comes in bottles of 25 and 100. Won't you prescribe
Filmtab ERYTHROCIN—soon?

Erythrowsin Stearste, Abbott

LETTERS

under the year when the suit was filed. Now, it's quite rare for a claim to be made during the policy year in which the incident occurred—or even the year after. Suits for a specified year may sometime be filed four, five, six, or more years later.

So the number of suits in 1953 only nineteen so far—may have to be tripled when the data are reviewed, say, three years hence . . .

> Joseph F. Sadusk Jr., M.D. Oakland, Calif.

Dr. Sadusk is correct in saying that it's still too soon to make a final evaluation of the 1953 figures. However, our optimism was based on other factors, too. As Howard

Hassard, legal counsel for the California Medical Association, points out, fewer claims and suits per thousand physicians insured have been filed in Northern California recently. In addition, case analysis shows that the number of unwarranted or "nuisance" suits is declining. Says Mr. Hassard: "Since there is no way to anticipate in advance how many late or 'sleeper' claims will arise, our opinions can be only opinions and nothing more. .I do know, though, that some of the attorneys in this area who used to file a malpractice suit at the drop of a hat now give the matter considerable thought before rushing to court."-Ep. END

Sandril

(DESERBINE LILLY)

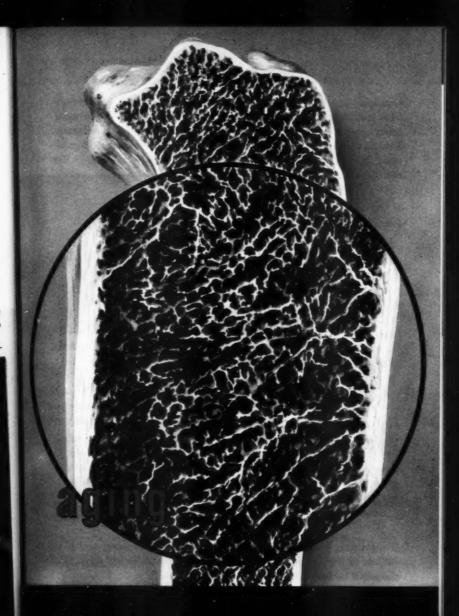
In hypertension, 'Sandril' often produces the desired reduction of blood pressure. In severe cases, 'Sandril' supplements the action of 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly).

SUPPLIED:

Tablets—0.1, 0.25, and 1 mg. Elixir—0.25 mg. per 5-cc. teaspoonful.







changes the hone picture

Osteoporosis occurs in both sexes, but is more prevalent in the female.² This is explained on the basis that "gonadal function in old persons is more markedly reduced in females than in males." It is easy, therefore, to understand why the aging process, with its accompanying decline in sex hormone function, is more frequently responsible for osteoporosis.

CLINICAL SIGNS PRECEDE X-RAY DETECTION

Clinical manifestations of osteoporosis usually appear long before x-ray evidence of the disease can be obtained. It is virtually impossible to detect with Tibia, magnified sagittal section

- 1. Typical rarefaction of bone matrix due to osteoporosis.
- 2. Normal, fully calcified osseous structure.

2.

accuracy any change in bone density until at least 30 per cent of the normal calcium content is lost.

■ SIGNS AND SYMPTOMS

- · "Low back pain" or dull, tired, aching feeling along the spine
- Nervousness, weakness, easy fatigability
- · "Rounding" of the shoulders
- Increased susceptibility to fracture, particularly of the hip, in elderly women

Osteoporosis is almost "physiologic" after the menopause, and if all women in this age group "are carefully studied, about 10 per cent of them will be found to have clinical osteoporosis." ³

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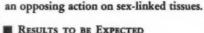
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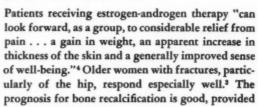
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RATIONALE OF THERAPY

Estrogen stimulates osteoblastic activity and increases calcium and phosphorus retention, while androgen exerts an anabolic or proteinforming action. "Premarin" with Methyltestosterone therapy utilizes the complementary action of estrogen and androgen on bone and pro-

tein metabolism. The incidence of undesired side effects is minimized because the two steroids exert





therapy is continued for extended periods.

■ SUGGESTED DOSAGES

"Premarin" with Methyltestosterone may be administered in the following dosage schedule: 2 or 3 tablets No. 879 (yellow) daily, or 4 to 6 tablets No. 878 (red) daily.

In the female, it is suggested that combined therapy be given in 21 day courses with a rest period of about one week between courses, and be continued for 6 to 12 months; following this period, the patient may be maintained with cyclic therapy employing "Premarin" Tablets alone.

In the male, a careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

- Albright, F., and Reifenstein, E. C., Jr.: The Parathyroid Glands and Metabolic Bone Disease, Baltimore, The Williams & Wilkins Company, 1948, p. 145.
- MacKenzie, D. A., and Janes, J. M.: Canad. M. A. J. 7l:339 (Oct.) 1954; abstracted, Mod. Med. 23:142 (Feb. 1) 1955.
- Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, Philadelphia, The Blakiston Company, 1950, p. 655.
- 4. Hart, G. M.: Geriatrics 5:321 (Nov.-Dec.) 1950.

Climacteric (female)

(in certain cases)

In the majority of patients, estrogen therapy as provided by "Premarin" alone is the ideal choice for the relief of menopausal distress. However, in certain selected cases, particularly when the menopausal syndrome is complicated by functional uterine bleeding or cyclomastopathy, the combination of estrogen and androgen may provide greater benefit with minimum danger of side effects.

Other Indications

- Osteoporosis
- Postpartum Breast Engorgement
- Dysmenorrhea
- Climacteric (male) in certain cases
- Malnutrition (in the female)
- As an adjunct to treatment with cortisone in rheumatoid arthritis

SUPPLIED IN TWO POTENCIES: the *yellow* tablet (No. 879) contains 1.25 mg. of conjugated estrogens (equine) and 10 mg. of methyltestosterone; the *red* tablet (No. 878) contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

Complete information on therapy may be obtained from your Ayerst representative or by writing to Ayerst Laboratories, 22 East 40th Street, New York 16, N. Y.

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"That's what I'd call a 'Polysal recovery'!"



Polysal, a single I.V. solution to build electrolyte balance, is recommended for electrolyte and fluid replacement in all medical, surgical and pediatric patients.

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ours Free your office in advance. Steelux OFFICE

> 1.) I. D. ORAMA. Five-piece model Steelux examining room suite; floor is scaled. Shift each piece at will to determine where it fits best and looks best.

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3.) STEELUX BROCHURE. Full-color display of mod-ern, matching Steelux examining room furni-ture and accessories; most complete selection available.

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Suggests ideal room arrangements. Shows how to place equipment for best use, smoothest traffic flow, greater efficiency and PROFITS.



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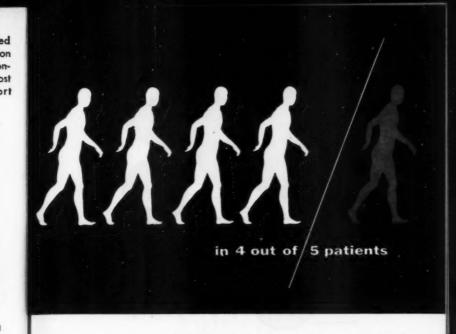
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WRITE Shampaine Company, Dept. ME 5-5. 1920 S. Jefferson, St. Louis, Mo. for the name of your nearest Steelux dealer, He will be happy to give you your Steelux Office Planning Kit free, without obligation,



you can prevent attacks of angina pectoris

Peritrate, a long-acting coronary vasodilator, has repeatedly demonstrated its effectiveness in preventing attacks of angina pectoris in 4 out of 5 cases.^{1,2,3}

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Peritrate's action is similar to that of nitroglycerin but considerably more prolonged . . . "favorable action [can] be elicited for 5 hours or more after its administration."

Usual dosage is 10 to 20 mg. before meals and at bedtime.

The specific needs of most patients and regimens are met with Peritrate's four dosage forms. Peritrate is available in both 10 and 20 mg. tablets; Peritrate Delayed Action (10 mg.) allows uninterrupted continuation of protection through the night. Peritrate with Phenobarbital (10 mg., with phenobarbital 15 mg.) where sedation also is required.

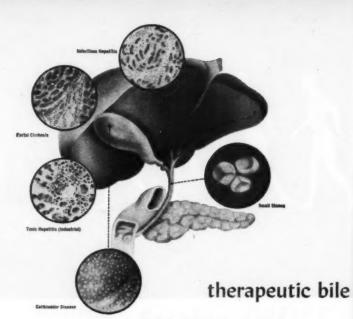
1. Winsor, T., Humphreys, P.: Angiology 3:1 (Feb.) 1952. 2. Plotz, M.: N. Y. State J. Med. 52:2012 (Aug. 15) 1952. 3. Dailheu-Geoffroy, P.: L'Ouest-Médical, vol. 3 (July) 1950. 4. Russek, H. I., et al.: Am. J. M. Sc. 229:46 (Jan.) 1955.

Peritrate^{*}

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in liver and gallbladder disorders

"...due to the production of true hydrocholeresis-

a marked increase both in volume and fluidity of the bile."*

"...the objectives of the principal therapy cannot but be furthered....".

"...confirmed further by the clinical experiences reported."

DECHOLIN® and DECHOLIN SODIUM

(dehydrocholic acid, Ames)

(sodium dehydrocholate, Ames)

Decholin Tablets, 3% gr. (0.25 Gm.); bottles of 100, 500, 1000. Decholin Sodium, 20% aqueous solution; ampuls of 3 cc., 5 cc. and 10 cc.; boxes of 3, 20 and 100.

Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. 16:102, 1953.



AMES COMPANY, INC . ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

Ulcer protection that lasts all night:

Pamine*Phenobarbital

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Tablets

Each FULL-STRENGTH tablet contains:

Phenobarbital... ...15.0 mg. (¼ gr.) Methscopolamine bromide. .. 2.5 mg.

Dosage:

One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Each HALF-STRENGTH tablet contains:

Phenobarbital 8.0 mg. (1/4 gr.)

Methscopolamine bromide 1.25 mg.

Dosage:

While the dosage and indications are the same as for the full-strength tablets, this tablet allows greater flexibility in regulating the individual dose, and may be employed in less severe gastrointestinal conditions. Supplied:

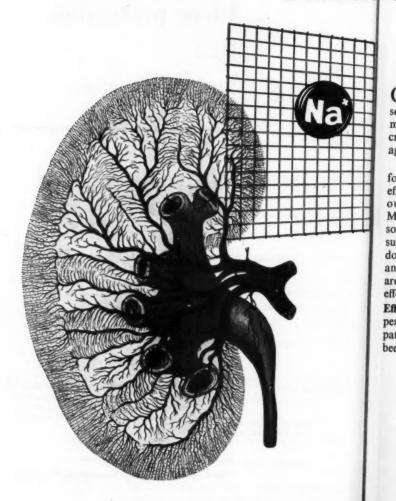
Both strengths in bottles of 100 tablets.

REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF METHECOPOLAMINE

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Diuresis 1

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Increased sodium ion excretion following administration of Mictine indicates the inhibition, or "screening," of reabsorption of this ion, as well as increased elimination of water and chloride.

sis by "Sodium-Screening" Action

Features the New Orally Effective, Well-Tolerated, Non-Mercurial Diuretic Agent

Culminating many years of research, Mictine, brand of aminometramide, fulfils the following criteria for an improved diuretic agent:

Mictine, neither mercurial, sulfonamide nor xanthine, is orally effective, well-tolerated and without known contraindications. Mictine causes excretion of water, sodium and chloride in amounts sufficient to reduce edema, yet does not upset the acid-base balance because only neutral salts are excreted. It is continuously effective with minimal side effects.

Effectiveness—Approximately 70 per cent of unselected edematous patients treated with Mictine have been found to respond with a

satisfactory diuresis. This response is considerably greater when used in the control of the edema of congestive heart failure in patients with normal kidney function.

Clinical Field—Mictine is useful primarily in the maintenance of an edema-free state and in the initial and continuing control of patients with mild congestive failure. Mictine may be used also for initial and continuing diuresis in more severe congestive states, particularly when mercurial diuretics are contraindicated.

Administration—The usual dosage for the average patient is one to four tablets daily in divided doses with meals and on an interrupted schedule. The latter may be accomplished by giving the drug on alternate days or for three consecutive days and then omitting it for four days.

For severe congestive states the dosage is four to six tablets daily with meals, also in divided doses on interrupted schedules.

Supplied—Uncoated tablets of 200 mg.

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*Trademark of G. D. Searle & Co.

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New TENSOR adjusts itself to the swelling

Maintains proper support without constriction-throughout every stage of swelling

Here's an elastic bandage that can give and take with the swelling.

Tensor elastic bandage is made with live rubber threads. Unlike bandages made with ordinary rubber, Tensor never constricts. Never binds. Gives perfect support during every stage of swelling.

And with Tensor, Doctor, you can bandage for low pressures as easily as higher pressures. Tensor elastic bandage holds whatever pressure you apply.

Shouldn't your patients have the advantages of new Tensor elastic bandage?

NEW! PLASTIC ENDS eliminate bulky pressure points - easier, safer to apply.

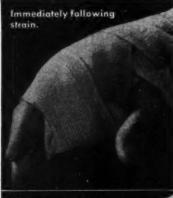
New TENSOR® **ELASTIC BANDAGE**

Woven with Heat-Resistant live rubber threads

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Division of The Kendall Company

SPECIAL FOR DOCTORS: save 32% when you order in bulk.







'Thorazine' is "an effective agent for blocking the mechanism of nausea and vomiting..."

This conclusion was reached after a study of 'Thorazine' in 336 patients with severe nausea and vomiting from many different causes, including the following:

> drugs such as digitalis, aminophylline, antibiotics and morphine; infectious or toxic reactions, such as gastroenteritis; congestive heart failure; peptic ulcer; intestinal obstruction; general anesthesia; and pregnancy.

> > Moyer et al.: A.M.A. Arch. Int. Med. 94:497 (Sept.) 1954.

THORAZINE*

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) ampuls and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.). Information available on request.

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*Trademark for S.K.F.'s brand of chlorpromazine. Chemically it is 10-(3-dimethylaminopropyl)-2chlorphenothiazine.



do you refer your tubal patency tests?

If so, this message is worth your attention.

Some 17 of every 100 married couples are childless. In half of these the female is at fault, and the commonest cause of female infertility is occluded fallopian tubes.

With the KIDDE TUBAL INSUFFLATOR, tubal insufflation for either diagnostic or therapeutic purposes is rendered safe, simple, and economical.

Pure, filtered CO₂, the medium employed, is promptly absorbed—no risk of emboli.

Pressure is limited to 200 mg. Hg, automatically controlled by the most constant force known—gravity.

The quantity of gas delivered is limited to 100 cc., and the rate of flow is controlled at your fingertip, precisely revealed at all times by the Flow Meter.

Charging the apparatus is accomplished in seconds, with a disposable, hermetically sealed cartridge.

And—the low cost of the KIDDE TUBAL INSUFFLATOR assures that it will pay for itself in half a dozen uses, assuming the usual fee of \$20 to \$30 for a tubal patency test.

the KIDDE tubal insufflator



The most completely safe instrument for tubal insufflation available

Tubings and fittings are provided for attaching your own manometer. A kymograph may be connected if desired. For instilling contrast media for salpingography, the Kidde Opaque Oil Attachment is also available.



Ask your dealer to demonstrate, or write for information to

RIDDE Manufacturing Company Bloomfield New Jersey Kidde, Trademark Reg. U.S. Pat. Off. Table shown is from the handsome Nu-Trend suite. But the brilliant new beauty and efficiency are typical of all Hamilton equipment . . . Fully adjustable Fit-All stirrups, for example, can now be moved in and out of concealment without lifting table's foot end . . Plastic paper cutter for the clean STER-O-SHEET table covers in one both adjustable and removable.







Patience was a key word in the development of the new Hamilton examining room equipment. Patience till the finest built was built even better . . . features already famous for efficiency and convenience, actually improved . . . designs, finishes, and upholsteries evolved to make your

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office more attractive and pleasant to work in than ever before.

That it was well worth the waiting, you'll surely agree when you look through the intriguing new five-color Hamilton catalog. Write today for your free copy; better still, see your Hamilton dealer.

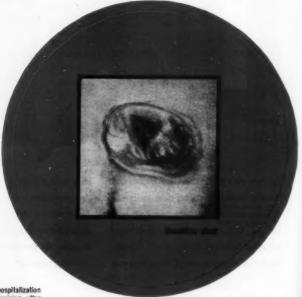
HAMILTON MANUFACTURING COMPANY
Two Rivers 10, Wisconsin



TREAT this difficult condition with

Parenzyme Mramuscular trypsin

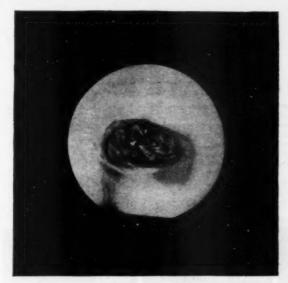
to control inflammation in a wide range of vascular and traumatic conditions - to restore local circulation



BEFORE:

Patient, 78; lengthy hospitalization from slow-healing incision after prostatectomy. Decubitus ulcer developed during 6th week. Usual therapeutic measures failed.

Safe . Not an anticoagulant



OBTAIN striking improvement

AFTER:

Parenzyme Intramuscular Trypsin, intragluteally (2.5 mg. q. 6 h.) 4 days: then twice daily, Exudate disappeared in 72 hours; granulation and friability became evident; healing rapid thereafter. Patient ambulatory in 2 weeks.

TIME BETWEEN PHOTOS: 3 WEEKS

OTHER INDICATIONS:

Skin ulcers decubitus diabetic varicose

Traumatic wounds slow-healing wounds bruises, contusions black eyes

> Vascular disorders phlebitis thrombophlebitis phlebothrombosis

Ophthalmic disorders iritis iridocyclitis chorioretinitis

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IMPORTANT CLINICAL REPORTS:

Innerfield, I., Trypsin Given Intramuscularly in Chronic, Recurrent Thrombophlebitis, J.A.M.A., 156:1056-1058 (Nov. 13) 1954.

Golden, H., Intramuscular Trypsin, Its Effect in 83 Patients with Acute Inflammatory Disorders, Del. State Med. J., 26:267-270 (Oct.) 1954.

Additional clinical information on request.

DOSAGE: 2.5 mg. (0.5 cc.) intragluteally q. 6 h. until improvement results; q. 12 h. thereafter.

5-cc. multiple-dose vials (5 mg. trypsin/cc.)

The National Drug Company, Philadelphia 44, Pa.

Compatible with antibiotics and other therapy

for peptic ulcer

ROBALATE'

provides two-way protection, with an antacid-demulcent action superior in many ways to that of dried aluminum hydraxide gel. It is 42% more efficient in acid-consuming power2...mare rapid in its neutralizing action1...ls not inhibited by pepsin3...does not disturb bowel activity4 .. and its effectiveness is not diminished by age.3

Each tablet contains: Dihydroxy aluminum aminoacetate....0.5 Gm.

blocks acid erosion blocks local irritation

blocks a hyperactive vagus blocks emotional tension

MAY

BEQUIRE

DONNALATE' Robins

provides four-way protection, with Robalate's superior antacid-demulcent action, plus Donnatal's recognized spasmolytic-sedative effectiveness.

Each tablet contains: Dihydroxy aluminum aminosa .0.5 Gm. .0.052 mg. Hyoscyamina sulfate Atropine sulfategm 010.0. Hyoecine hydrobromide .0.003 mg. Phenobarbital (1/2 gr.)... .8.1 mg.

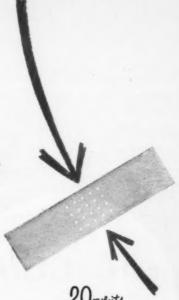
(Each Donnalate tablet ...

1 Robolate tablet + 1/2 Dannatal tablet)

Both Robolate and Donnalate are free from grittiness and the chalky feeling usually associated with many antacids...free from side effects, such as systemic alkalosis and disturbance of bowel activity.

DOSAGE: 1 or 2 tablets after each meal and before retiring, or as directed. SUPPLY: Bottles of 100 and 500 white (Robalate) or yellow (Dennalate) tablets.

A. H. ROBINS CO., INC. . RICHMOND 20, VIRGINIA Ethical Pharmacouticals of Morit since 1878 DOCTOR...
have you seen this?
New BAND-AID Plastic Strips
with Multi-vent Holes



20-vents

* Maximum aeration

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* Full protection

Exclusive with

BAND-AID Plastic Strips
with SUPER-STICK

The most trusted name in surgical dressings . . .

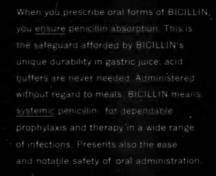
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Benzathine Penicillin G Dibenzylethylenediamine Dipenicillin G for those

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VITERRA®

Therapeutic formula
11 minerals, 9 vitamins—
for prompt nutritional
recovery following
illness. All in one soft
gelatin capsule.

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Supplemental formula
11 minerals, 10 vitamins—
ideal as the prophylactic
mineral-vitamin capsule.
All in one soft gelatin capsule.



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Editorials

Should doctors underwrite

their own malpractice insurance? • The odds on voluntary Social Security • Too few grievances • Custom-designed forms

Malpractice Protection

Ten years ago in New York State, there was one malpractice claim or suit for every seventy-one physicians. Five years ago, there was one for every forty-seven. Last year, there was one for every twenty-five.

This sharply rising incidence has scared insurance carriers as well as medical men. Nearly a hundred companies once offered malpractice policies in New York. Less than half a dozen still do.

On hearing these statistics, men who practice elsewhere sometimes shrug and say: "That's New York for you!" They should look closer to home. The same rising incidence, the same dwindling choice, can be observed in almost every part of the country.

What can physicians do about it? A major article in this issue gives some practical answers. But one possibly *im*practical answer seems worth citing editorially:

Suppose that a group of physicians took the lead in setting up a small insurance company. Suppose they secured the necessary capital

from local colleagues and lending institutions. Suppose they hired experts to work out the legal and actuarial details. Suppose they provided malpractice insurance without the usual loading for advertising and commissions and profits . . .

It's not a new idea, of course. But today it's being talked up more than ever before. "This," one medical leader suggests, "may be the only way we can get permanent protection against malpractice suits. And I wouldn't be surprised if we could get it for one-third less than we're paying now."

Would doctors be fools to rush in where insurance men fear to tread?

Not necessarily. As far back as 1902, the Omaha doctors who founded the Physicians Casualty Association (a mutual insurance company) showed that it could be done successfully. And in Britain today, most malpractice insurance is provided by doctor-owned "defense societies"—nonprofit local companies, reinsured by Lloyd's of London.

We'd like to see some such idea put to the test in America today. It shouldn't be done nationally; the



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FOR THE HYPERTENSIVE

Because of the tendency of hypertension to progress from mild to severe, it is all the more important to institute therapy in the early stages of the disease, long before the fundi show any changes, in the aim to arrest progression.1 The management of early, labile hypertension proves rewarding to both patient and physician. Of such mild cases, up to 80 per cent respond to therapy with Rauwiloid alone.2 In the more advanced cases of hypertension Rauwiloid-in addition to its own beneficial actions-reduces significantly the dosage requirements of more potent hypotensive drugs when used in combination with them.

A More Confident Outlook in the Aim to Arrest Progression

"One has...every reason to believe that the disease may now be controlled in its incipiency and consequently the serious later complications prevented..." Early management, carried out with the ease and simplicity afforded by Rauwiloid, yields rich returns—not only in the resultant tranquil sense of well-being and control of hypertensive symptoms, but also in a confident outlook to a new future of prolonged useful life.

The dosage of Rauwiloid is definite...merely two 2 mg. tablets at bedtime. For maintenance, one tablet often suffices. No contraindications...no cumulative side actions.

- Finnerty, F. A., Jr.: The Value of Rauwolfia Serpentina in the Hypertensive Patient, Am. J. Med. 17:629 (Nov.) 1954.
- Moyer, J. H., in discussion of Galen, W. P., and Duke, J. E.: Outpatient Treatment of Hypertension with Nexamethonium and Hy-dralazine, South. M. J. 47:858 (Sept.) 1954.
- 3. Livasay, W. R.; Moyer, J. H., and Miller, S. L.: Treatment of Hypertension with Rauwolfia Serpentina Alone and Combined with Other Drugs; Results in Eighty-Four Cases, J.A.M.A. 155:1027 (July 17) 1954.

Rauwiloid

THE FIRST THOUGHT IN HYPERTENSION



Riker | Laboratories, Inc., los angeles, calif.

risks are too numerous. Perhaps even 15,000 physicians (as in the New York group plan) are too many to experiment with. But a smaller group might well consider a pilot plan of self-insurance.

A last resort? You might call it that. Much more immediate solutions to the malpractice problem are better prevention and better defense. Doctors don't have to start their own insurance company to get these.

tnese.

But, quite clearly, self-insurance would be better than no insurance. The idea merits careful exploration by groups of doctors who may feel (as some already do) that they're down to their last carrier. Some

sturdy pioneering here could conceivably change the whole pattern of malpractice protection in this country.

Social Security Shift

Self-employed lawyers and physicians are two of the major occupational groups still outside the Social Security system. They are outside because their professional organizations convinced Congress last year that "there is no sound reason for compulsory coverage of a group against their expressed wishes."

Since then, one of the two professional organizations—the American Bar Association—has significantly



*Specially processed malt extract aeutralized with potassium carbonate. In 8 az. and 16 az. battles.

1. Cass, L. J. and Frederik, W. S.; Malt Soup Extract as a Bowel Content Madifier in Geriatric Constitution, Journal-Lancet, 73:414 (Oct.) 1953.

Send for Sample BORCHERDT MALT EXTRACT CO.
217 N. Welcott Ave. • Chicago 12, III.

Soup Extract provides corrective therapy for the colon, tool

DOSE: 2 tablespoonfuls b.i.d. until stools are soft

(may take several days), then 1 or 2 Tbs. at bedtime.

shifted its emphasis. This recommendation from its board of governors is now A.B.A. policy:

"In view of the present sentiment of the members of the legal profession in favor of voluntary Social Security coverage, the board of governors recommends . . . that the American Bar Association favor voluntary coverage under the Social Security Act for lawyers and such of the professional groups as desire to be included."

Are physicians among those who "desire to be included"? MEDICAL ECONOMICS queried 8,000 of them in 1952, and almost half (45 per cent) said yes. Two years later, another (cross-sectional survey indicated

that more than half (54 per cent) wanted Social Security.

If these sentiments still hold—and we've seen no evidence that they don't—the A.M.A. might well stand beside the A.B.A. in fighting for voluntary Social Security. With this shift of emphasis, optional coverage might become a reality. Without it, compulsory coverage could be fastened on us despite our protests.

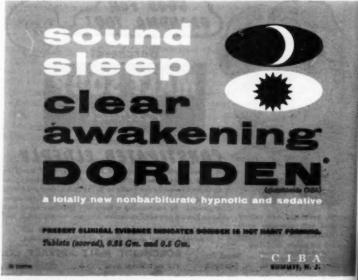
Too Few Grievances

Not enough patients registered complaints last year with the grievance committee in Atlanta, Ga. Thirtyeight did, the committee's chairman reports. But another 400 lodged

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To the





Mucilose — highly purified hemicellulose from psyllium seed — produces gentle, stimulating, bland bulk, physiologically initiating normal peristaltic waves in the large intestine and at the same time soothing the irritable colon.

Superior Effectiveness

Mucilose absorbs as much as 50 times its weight of water which it effectively retains during passage through the bowel, producing a pliable, demulcent stool.

Increased Convenience

To the greater effectiveness of Mucilose is added the increased convenience and flexibility of a variety of dosage forms to meet varied needs:

 MUCILOSE COMPOUND TABLETS, Mucilose with methylcellulose; bottles of 100 and 1000.

Greater Bulk · Smaller Dosage · Convenient · Easy to Swallow

• MUCILOSE SPECIAL FORMULA Flakes or Granules

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MUCILOSE CONCENTRATED Flakes

in tins of 4 oz. and 1 lb.

2. Contractions 24 hours

after ingestion of Mucilose

Mucilose should be taken with 1 or 2 glasses of water.

NEW KORK 18, N.Y. WINDSOR, ONT

Visit our Booths No. B 12-14 and G 11-13 A.M.A. Convention, June 6-10, 1955.

EDITORIALS

complaints with various employes of the medical society—complaints that sounded as if they should be investigated, but never were.

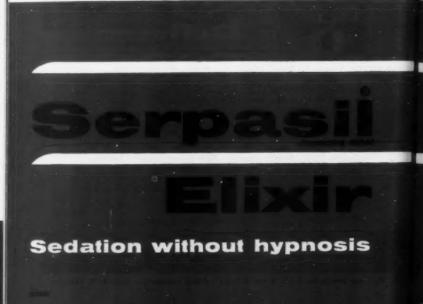
Why weren't they? Because complaints have to be put in writing for grievance-committee consideration. Despite repeated urging, these 400 disgruntled patients didn't bother.

This phenomenon is familiar to grievance committees everywhere. So is the feeling that something should be done about it. But what?

Here, in our opinion, are the things doctors must do to make their mediation machinery really work:

1. Build public awareness of the grievance committee through sustained advertising. This may sound like asking for trouble. On the contrary, it's the best way to nip trouble in the bud. Doctors in Lexington, Ky., and Imperial, Calif., are among those who have sponsored notably successful advertising campaigns. They bring grievances into the open and draw them into the only channels where doctors can resolve them, learn from them, and correct the causes.

2. Build public faith in the grievance committee through carefully controlled publicity. This means combating the notion that doctors "cover up each other's mistakes." It means letting people know the results of grievance committee hearings (they're usually surprised to



hear how many decisions favor the patient). And it means letting the patient know he can appeal if he's not satisfied.

Custom-Designed Forms

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Some of the best forms designed for use in the medical office are not widely available. These are the forms dreamed up by some doctor, then produced for him individually by a local printer.

In recent months, we've described several such forms in MEDICAL ECONOMICS. One was a pocket-size notebook for recording house calls, hospital calls, and related financial matters. Another was a "health question-

naire" that patients can fill in before seeing the doctor.

After each of these articles appeared, many doctors wrote us saying: "Where can I get such forms?" The plain fact is, they're not nationally available. But that shouldn't stop any doctor from adapting the basic idea to his own practice and placing the order with a local printer.

This, in fact, is how most new forms are developed. They're tested in actual practice long before they get into the catalogues of the big professional printers. So don't hesitate to place your own print orders locally. It may be the only way to get exactly the forms you want.

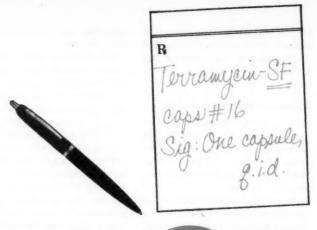
-H. SHERIDAN BAKETEL, M.D.

Monsoportilic tranquilizer

Especially indicated for Old People and Children

Highly compatible vehicle

New SERPAUL SCRIE is supportate with Pyripersumines State, destro-empherance suffets other, Antronyis Syrup, cadeing pheophets, eshedring suffats other, Antronyis Syrup, cadeing pheophets, eshedring suffats, sedimit suffats and many, other modications. Serpaul Sillets had a clear light-grown dater and a pleasant temps. Kine flavor, Sash 4-mi, tempsoportal sentation 0.0 mg. of Serperli.



When you specify the Pfizer antibiotic of your choice Stress Fortified with the B-complex, C and K vitamins recommended by the National Research Council, be sure to write on your prescription

> The minimum daily dose of each antibiotic (1 Gm. of Terramycin or Tetracyn, or 600,000 units of penicillin) Stress Fortifies the patient with the stress vitamin formula recommended by the National Research Council:



Ascorbie seid, U.S.P. Thiamine mononitrate Riboflavin Niacinamide Pyridoxine hydrochloride

300 mg. Calcium pantothenate Vitamin B₁₂ activity 10 mg. 10 mg. Folic acid 100 mg.

4 mcg. Menadione (vitamin K analog)

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.

Retracyn-SF caps #16 Sig: One capsule, g.i.d.

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Retracyn-SF Oral Suspension 202. Sig: 2 teaspoonfuls, 8.i.d.

antibiotics Stress Fortified with vitamins include:

Terramycin-SF

Brand of oxytetracycline with vitamins CAPSULES 250 mg.

Tetracyn-SF

Brand of tetracycline with vitamins CAPSULES 250 mg.

ORAL SUSPENSION (fruit flavored) 125 mg./5 cc. teaspoonful

Pen-SF*

Brand of penicillin G potassium with vitamins

CAPSULES 200,000 units

*Trademark

ANEMIA OF PREGNANCY

Maintenance of normal blood values during pregnancy is a factor in the welfare of the mother at delivery and in preventing anemia in the infant. Improvement in the patient's vitality and emotional stability during gestation can also be achieved.

RONCOVITE, the original, clinically proved cobalt-iron product, has introduced a wholly new concept in the prevention and treatment of anemia. It is based on the unique hemopoietic stimulation produced only by cobalt. The application of this new concept routinely in pregnancy practically insures against the development of iron-deficiency; its use has also led to marked, dramatic advances in the successful treatment of many of the anemias.

In a recent clinical study of anemia in pregnancy, Holly¹ reports:
—about 80 per cent of normal patients manifest significant decreases in hematologic values during pregnancy.

—conversely, 90 per cent of pregnant women maintained hemoglobin levels of 12 Gm. per cent or over when given Roncovite (iron-cobalt therapy). No other medication tested was so successful.

—in fact, 63 per cent of these Roncovite treated patients delivered with the unusually satisfactory level of 13 Gm. per cent hemoglobin.

—Roncovite (iron-cobalt therapy) was proven to be the most effective hematinic. In fact, 57 of 58 patients (98.2%) maintained or improved their hemoglobin values.

RONCOVITE IS A SAFE DRUG.

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in. ost ed "No toxic manifestations associated with its use have been observed."1

In prematures-

"None of them showed harmful effects despite the large doses..."2

In pharmacology—

"Histopathologic studies of rats that received cobaltous chloride ... revealed no significant degenerative changes in parenchymal organs as evidence of toxicity."3

SUPPLIED:

RONCOVITE TABLETS

Each enteric coated, red tablet contains: Cobalt chloride..... 15 mg. Ferrous sulfate exsiccated..... 0.2 Gm.

RONCOVITE-OB

Each enteric coated, red capsuleshaped tablet contains:

Cobalt chloride...... 15 mg. Ferrous sulfate exsiccated..... 0.2 Gm.

Calcium lactate..... 0.9 Gm. Vitamin D..... 250 units

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides: Cobalt chloride

(Cobalt 9.9 mg.)..... 40 mg. Ferrous sulfate..... 75 mg.

DOSAGE:

One tablet after each meal and at bedtime. Children 1 year or over, 0.6 cc. (10 drops); infants less than I year, 0.3 cc. (5 drops) once daily diluted with water, milk, fruit or vegetable juice.

- Holly, R. G.: Anemia in Preg-nancy, Paper read at the Sixth American Congress on Obstetrics and Gynecology, Dec. 13-17, 1954, Chicago, Illinois.
- 2. Quilligan, J. J., Jr.: Texas State J. Med. 50: 294 (May) 1954.
- Hopps, H. C.; Stanley, A. J., and Shideler, A. M.: Polycy-themia Induced by Cobalt, Amer. J. Clinical Path. 24: (Dec.) 1954.

Bibliography, of 192 references available on request.

RONCOVITE

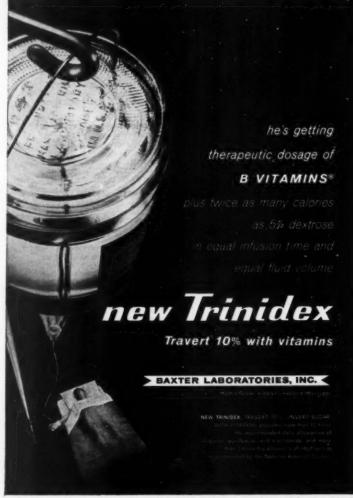
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OSTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKES (second in the city of El Paia, Team) THROUGH AMERICAN HOSPITAL SUPPLY CORPORATION SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES - EVANSTON, SELLINGIS

for your tense peptic ulcer patients



new ANTRENYL®-PHENOBARBITAL

depresses... ... gastrointestinal motility

... gastric acid secretion

... nervousness and irritability so common in the ulcer diathesis



SUPPLIED: Antrenyl-Phenobarbital Tablets (scored), each tablet containing 5 mg. Antrenyl and 15 mg. phenobarbital.

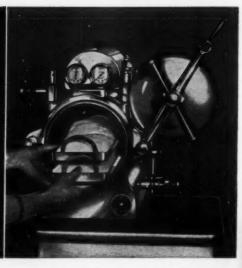
Other forms: Tablets, 5 mg. Syrup, 5 mg. per 4-ml, teaspoonful. Pediatric Drops, 1 mg. per drop.

Antrenyl® bromide (oxyphenonium bromide CIBA)

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There's no such thing as a minor operation



... said a famous authority on safety in operations. Any operation, he pointed out, is of major concern to the patient. Overlooking fundamental asepsis even in a simple case may result in a serious disability.

Protect yourself . . . your patients

Your patients have a right to expect thorough aseptic treatment in your office. They are not getting it if you depend only on boiling water to "sterilize" instruments. Too many sporulating bacteria survive boiling at 212° F. What is needed is moist heat of at least 250° F. And that calls for the certainty of autoclave sterilization.

A Pelton Autoclave brings to your office the safety plus the speed of hospital sterilization. Any one of the three Pelton models sterilizes fabrics, gloves and solutions as well as instruments. Each generates its own steam and stores it for immediate use.

See your dealer or write for literature describing Pelton Autoclaves.

Professional Equipment Since 1900



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for peptic ulcer pain⊋spasm PIPERIDOL ACTION

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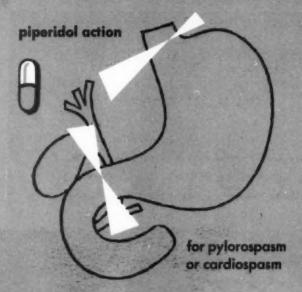
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- relief day and night with 1 tablet t.i.d.
 before meals and 1 or 2 tablets at bedtime
- urinary retention or constipation are not a problem





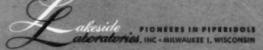
visceral eutonic

DACTIL

PLAIN AND WITH PHENOBARBITAL

relieves pain ≥ spasm usually in 10 minutes

prompt action at the site of visceral pain
prolonged control relieves up to four hours
well tolerated—does not interfere with digestive
secretions, normal tonus or motility





Things I've Learned About Investing

Here's a collection of investment hints from a former securities analyst who became an M.D. His views on the stock market are original and stimulating, if not always orthodox

By T. Kenneth Callister, M.D.

● You'll earn a million dollars or so (if you're an average medico) during your years of active practice. But how to make sure you'll still have a reasonable chunk of that million left when you retire?

Obviously, you've got to save some of your earnings and you've got to invest those savings profitably. Here are a few rules that have helped me in that direction; they may help you, too:

► Make sure you BELONG in the market. J. P. Morgan is credited with the remark that to succeed as an investor you have to have the "Triple C" combination—Capacity, Character, and Courage. His definitions:

Capacity: ability to withstand a temporary setback.

Character: ability to rise above the emotions (such as fear and greed) that sway the market as much as balance sheets and income statements do.

Courage: ability to follow your convictions on the merits of a stock that you've carefully investigated.

Learn by investing, not by theorizing. I visited an in-

THINGS I'VE LEARNED ABOUT INVESTING

ternist friend one night and found the desk in his den piled high with books and charts. The research proiect, he confessed, wasn't medical but financial.

"I'm trying to get some investment experience without risking any money," he said. "Last fall I picked out ten stocks and theoretically invested \$1,000 in each of them. Every week now I check my 'holdings' to see if I should sell or hang on. Seems to me like a good way to learn the ropes cheaply.'

"Jack," I said, "you're wrong. No one ever got an education in investment analysis by making only hypothetical purchases and sales. Most

of what you'll learn about the market will come from the mistakes that actually cost you money."

I advised him-as I would anyone-to learn by investing small amounts in carefully selected active stocks. Another thing worth adding: Start when you're young; then, by the time your earning power amounts to something, you'll have gained the investment wisdom that comes only from real market experience.

Manage your own investments. I've come to realize (from being both a doctor and an investment analyst) that most physicians suffer



He Mixes Medicine

If ever an M.D. makes a fortune on the stock market, then by all rights T. Kenneth Callister, Salt Lake City G.P., should be the man. The reason: Dr. Callister worked for a number of years as a professional investment analyst before he entered medical school, and he still enjoys investing as an avocation.

After graduating from Annapolis in 1934, he spent two years getting a Master's degree (cum laude) at Harvard's Graduate School of Business Administration-with a major in banking and investments. With from a common delusion: They think that any banker or broker knows as much about investments as a doctor knows about medicine. It just isn't so.

Actually, many doctors would make excellent investment managers: They've been trained from the start in dispassionate observation and reasoning; and these are the talents that successful investing demands most.

Don't buy stocks for their dividends (or bonds for their interest). The promise of a "safe, sound 6 per cent yield" has lured many an unwary investor to disaster-especially in a period of inflation, such as we've been witnessing recently.

What good, I ask you, is a 6 per cent dividend on a security if the security declines 6 per cent in value or if it continues to be worth the same number of dollars but the dollar value declines 6 per cent?

There's only one answer; and that's to invest for capital appreciation, not for dividends or interest.

Let your profits run. There's a dangerous axiom that many an investor has followed, to his sorrow. It says: "You can't go broke taking profits." What it means is this:

Say you bought a stock at 25, and

and the Market

that background he qualified successively as securities analyst at a Salt Lake City bank, director of a building and loan association, and comptroller of the Utah State Department of Health.

When he finally decided to give up the stock ticker for the stethoscope, he found his facility with figures a big help getting through Northwestern Medical School: Until the day before he was awarded his M.D. in 1945, he worked as a statistician for a Chicago firm.

Currently, he devotes about two

hours a week to investment study. In that time he reviews the records he keeps of all securities he owns or is interested in. He also reads the reports issued by various investment services plus the major financial publications.

As far as Dr. Callister knows, he's the only M.D. who's regularly invited to the annual conventions of the Security Analysts Society. "I often attend, too," he says, "though since I'm a physician now rather than a securities man, my expenses are no longer tax-deductible!"

THINGS I'VE LEARNED ABOUT INVESTING

it's now up to 35. You think it will probably go higher, but if you sell now, you're sure of some profit. So vou sell.

My advice is: Let your profits run as long as possible. Capital gain is the only goal of a wise investor-especially one who's wellheeled. So don't sell an issue while it's moving up. Wait till it shows definite weakness. A stop-loss order will protect you on the downswing from losing more than a modest slice of your profit.

Take your losses quickly. The hardest lesson the average investor has to learn is: Admit your mistakes and take the consequences unemotionally.

You can't expect to time the market perfectly or to select the right issues infallibly. But you can quickly tell your bad selections from your good ones, then dump the former and add to the latter.

▶ Don't let tax considerations keep you from selling. A short-sighted investor will sometimes hesitate to sell a stock that has reached its peak and is starting to slip. His reason: He's made so much on the issue that he feels the tax man will get an undue share.

This is sheer nonsense. For no tax rate is cheaper than the capital gains rate. So when the intrinsic value of a security is reflected in its current price, sell it. By reinvesting the proceeds in another promising issue, you'll make more than enough to pay the tax.

▶ Buy late and sell late. The perfect investor is described as the one who always buys low, just before the market starts to climb, and sells high, just before it begins to fall. That's what's known as "timing" a stock.

Some people claim they can achieve proper timing with theories based on levels of accumulation or distribution. But such theories rest on the illusion of a static investment temperament and an equally static national economy.

My own method of deciding when to take action is summed up in this rule of thumb: Buy late and sell late-but never too late in either case. In other words:

If you think you've discovered a low-priced stock that seems sure to rise, don't buy it until it has actually started up. Then, once you do buy, hang on until it has started down again.

Invest only on the prospect of a 25 per cent profit within a year. This sounds pretty arbitrary, but it's a rule that has several built-in safety factors. For example:

1. It means that you'll probably never be overinvested at any one time; for the number of stocks with a potential appreciation of 25 per cent a year is bound to be limited.

2. The rule tacitly (and realistically) anticipates some capital

losses, and tries to offset them by focusing entirely on achieving capital gains.

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3. You're forced to observe the first precept for investment success: Investigate thoroughly before you buy and observe performance after you buy. Actually, any stock that meets the 25 per cent test is bound to be so volatile that you'll have to check it carefully both before and after you risk your hard-earned money on it.

► Watch for patterns in market action. For instance: Some stocks—

like marathon runners—get a second wind. They advance initially on a speculative flurry of buying; then they settle back when the promotors and free-loaders pull out; and finally they forge ahead again on their intrinsic merit. It's possible that this may be the forthcoming pattern of uranium stocks.

► Don't delude yourself into thinking that bonds are the safest investment. Bonds—especially Government bonds—may seem solid as Gibraltar. But remember this: Money invested in bonds shrinks in



"Now, I want you to be quite frank with me."

real value every time the purchasing power of the dollar drops (which has been fairly often in late years).

► Choose the right industries. That's been the basic rule responsible for the success of the big institutional investors in the past decade.

When pension funds, college endowment funds, and similar trusts (that had previously invested mostly in very conservative securities) began to acquire their present huge holdings of common stock, their first step was to select the most promising industries. Then they diversified somewhat by buying several blue-chip stocks within each selected industry. As certain industries began to drop behind and others forged ahead, the institutional investors shucked their losing selections and piled their money on the winners.

- ▶ Reduce your investment risk by watching the quality, not the variety, of your holdings. Diversification (buying many stocks in many industries) has been grossly overrated as a safety measure. Careful selection of the best issues and continuous observation of their performance are the real keys to safe investment.
- ► Avoid the "old maids." Stocks are like women: They can be divided into the cute chicks that everyone's after and the old maids that nobody

wants. So to pick a winner in either case, you have to check her popularity rating. For a stock, it's simple:

If sales don't average over 400 shares a day, it's an old maid. And you'll never make a nickel on an old maid because it's just not attractive and no one will ever bid it up. So don't underestimate glamor—even in the stock market.

► Don't clutter your investment thinking. The intelligent way to select securities is by what I call the "narrowing-down technique." This frees you from the mass of market information that so often paralyzes the most decisive mind. Here's how the technique is applied:

1. Determine the general economic outlook for the next 12 to 18 months. (I've often done this merely by reading the articles in the Commercial & Financial Chronicle by Sumner Slichter, Professor of Economics at Harvard.)

2. Watch for the month-to-month economic changes. (You can do this by reading, say, Fortune magazine's "Business Roundup" department.)

3. Decide which industries and companies are most likely to benefit (or lose) from what's ahead. (You can estimate the relative popularity of different industries by watching changes in the portfolios of the better-managed investment trusts; but don't rely too heavily on the trusts' selection of individual companies.)

Closed-Panel Plans Are Hard to Beat in Court

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1-D They're tough to lick anywhere; and, as Southern California physicians found out recently, the courts aren't always the best places to try

By Claron Oakley

• Wherever medical men have made progress against the closed-panel plans—as in San Pedro, Calif., against the Henry J. Kaiser Foundation—they've done it by offering a better medical care program of their own, emphasizing free choice of physician and hospital. (In Henry J.'s own backyard last year, for instance, the San Pedro doctors' plan chalked up a 700 per cent membership increase.)

Legal action against the closed panels has been relatively less productive. For example, when the San Diego County Medical Society tried to slap down such a panel in court, on grounds that it was a corporation practicing medicine, the medical society got slapped down instead.

The San Diego case was appealed all the way up to the California Supreme Court. But to no avail. The court decided against the medical society and in favor of the Complete Service Bureau, a closed panel of ten physicians and a lay management headed by the late William David Parmer.

Here in brief are the medical society's charges and the court's reasons for rejecting them:

The charge: Since its manager is a layman, the Complete Service Bureau is a corporation illegally engaged in the practice of medicine.

The court: Not so. The panel physicians handled the patients medically as they saw fit and did not "encounter any lay interference with their practice of medicine."

Fee Splitting

The charge: Manager Parmer and the staff physicians were engaged in fee splitting. Parmer's twenty-year contract gave him 25 per cent of the monthly dues paid by members and 25 per cent of all gross revenue received from any source. The bureau also billed the private patients of its staff physicians and remitted only half of each fee to the doctor.

The court: That's not fee splitting. Fifty per cent for overhead is "a proper amount for the reason that most men who have practiced medicine for a number of years have found that that is substantially what it costs a man to operate his private business." There's nothing wrong (the court added) with using company money to pay the rent and to employ a business manager like Parmer.

The charge: The panel was "engaged in misleading advertising." Exhibit A was an ad proclaiming: "Surprise! A twenty-four-hour medical-surgical hospital service for only \$2.50 a month. You will be surprised how much medical, surgical, and hospital care you can buy for \$2.50 a month."

The court: Not so. No one is misled. "No subscriber thinks he is going to receive complete medical, surgical, and hospital care by prepaying \$2.50 a month. All of the C.S.B.'s members were advised of the medical fee schedule which was part of their contract." Furthermore, the "phrase 'prepaid medical plan' is employed by both the C.S.B. and the California Physicians' Service [Blue Shield] in their advertising. But neither one really offers what might be called a fully-prepaid medical plan-a plan which entitles a member to full medical service on prepayment of his dues . . . The literature explains all this. No one is deceived: no one is misled."

No Violation

The charge: The C.S.B. violated that section of California's Business and Professional Code which says: "The employment of 'cappers' or 'steerers' or other persons in procuring practice for a practitioner . . . treating the sick or afflicted . . . constitutes unprofessional conduct . . ."

(A "capper," says Webster, is slang for "a decoy, as for gamblers.")

The court: Not so. "The evidence shows that [other] nonprofit medical service groups solicit members. The California Physicians' Service... and the Complete Service Bureau both engage in newspaper advertising to secure new members. Both have membership drives."

Two of the State Supreme Court justices were on organized medicine's side in the final decision. Their reasons for dissenting sum up in large part the medical society's view of the problem.

Said one justice: "In the long run, to ignore unlawful practices incident to them [prepaid medical care plans] will benefit neither the public nor the profession. I hold that the Complete Service Bureau's division of the medical fees received by it with its business manager and group

properties on a percentage basis constitutes an unlawful medical practice, and enjoin its continuance."

Added the second justice: "If the mere device of forming such a corporation could legalize activities which were otherwise illegal, then such corporations could be organized for the purpose of permitting laymen and lay agencies . . . to intervene for profit in establishing the relations between members of the public and a single practitioner . . .

"Heretofore, such arrangements



"It isn't anything spelled backwards. It's Latin."

have always been declared to be against the public policy of the state; and if any change in policy is to be made, that change should be declared by the legislature, rather than by the courts."

The court majority has refused to review its decision, and the case can't be carried to the U.S. Supreme Court, unless an interstate angle can be proved.

It Opens Loopholes

California Medical Association tacticians see these immediate dangers in the ruling:

 Moves by medical societies to bar closed-panel doctors from membership may well prompt legal reprimands and anti-trust action.

Go-between laymen may now feel encouraged to solicit prospects for surgical and medical care, in exchange for a share of the doctor's fee.

 Hopes for a solid front of organized medicine against the closedpanel plans may crumble by what some Los Angeles medical leaders call a "fragmentation process."

With the ink scarcely dry on the California Supreme Court decision, quick-moving middlemen between patients and doctors are already darting through what the California Medical Association calls the "everwidening loopholes in the professional code." One officer in the Los Angeles County Medical Association recently said:

"Some of our best surgeons are

putting their services on the auction block to any middleman who wants to buy them. If some eager sicknessbroker can fill the surgeon's operating calendar from 8:00 to 5:00, three days a week, the M.D. can afford to give half a reduced fee to a middleman and still close his office two days a week to play golf.

"After all," he added, "isn't it better to sell twenty loaves of bread at ten cents a loaf, than to charge twenty cents and sell only five?"

Typical of this trend toward surgical bartering is an appeal sent recently by one California hospital to all the physicians in its area. It asked them to consider a proposal to provide hospital surgical services to some 200,000 aircraft factory workers and their families. The hospital wrote:

"The endorsement of our services by the management of these companies hinges upon the ready availability of a panel of doctors who will offer their services in conjunction with [this] hospital and comply with surgical fee schedules currently in effect [maximum: \$350]. We realize that there are inequities in the schedules, but we also feel that there is an opportunity through these affiliations which will be beneficial to all."

How Bad Is It?

Alarmed at reports of more and more steerers and cappers pounding at the doors of Los Angeles physicians, the L.A.C.M.A. council has asked its board of trustees for money to investigate the situation and to document charges.

One discouraged M.D. asked me: "Why should we waste our time working on fee schedules and building a unified front against closed panels if the courts are going to legalize fee splitting and let any and all enter into the doctor-patient relationship?"

A New Pattern

This doctor may be a pessimist. But it's hard for even the most optimistic to deny that the California decision has helped entrench closedpanel medicine. The pattern now developing in California can hardly be confined to that state. It can—and most probably will—be copied elsewhere.

Meanwhile, the San Pedro doctors, battling the Kaiser plan on its home grounds, may have the right idea (see MEDICAL ECONOMICS, February, 1955, "They Met the Challenge of Panel Medicine"). They say, in effect:

"You can't stamp out your closedpanel rival; but, under the doctors' plan, you can offer something he can't: Free choice of physician. We can say (and our rivals can't): Go to your own family doctor. Go to any hospital in the world!"



"Well, it's about time! I was going to start without you!"

An Eyewitness Reports On Soviet Doctors

• If you'd ever tried to find out what it's like to be a present-day Russian doctor, you'd have discovered how scarce facts really are. But now one M.D. from the Western world has visited the Soviet Union and turned in an exceptional report: It's apparently free of the sound of propaganda on the one hand and the fury of blanket condemnation on the other.

This firm-footed observer is Dr. T. F. Fox, a prominent British physician who's the editor of The Lancet. Dr. Fox is one of seventeen doctors who spent three weeks behind the Iron Curtain last September on a medical sightseeing junket arranged by the (British) Society for Cultural Relations with the U.S.S.R.

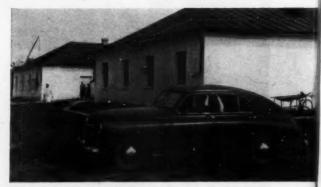
How much were he and his colleagues allowed to see? Enough, says Dr. Fox, to draw some fairly solid conclusions. Apparently, the Russians showed unexpected willingness to depart from the official itinerary when any of the British visitors made special requests. In fact, Dr. Fox noted less difficulty in visiting institutions he wanted to see than he had in 1936, on a previous trip.

Dr. Fox took notes at considerable length for The Lancet. We've picked out the highlights accenting conditions that are strangest to Western eyes (the Russian doctors, for example, couldn't understand what Dr. Fox meant by a "family doctor"). And we've used them—quoting the author directly—as captions for the official Sovfoto pictures appearing on these pages.



primary loyalty is towards the State, not towards the patient who consults him. He does not regard himself as an individual practitioner, assuming full charge of his patient and exercising full responsibility, but rather as a member of a service; he does not practice from his private house but from a medical station, dispensary, clinic, or hospital, which is the local outpost of the service and where he forms one of a medical team." (Cut shows Dr. Igor Tsynkalovsky, examining patient in physiotherapy room at Krasnodar hospital.)

REPORT ON SOVIET DOCTORS



NO FAMILY PHYSICIAN: "The district doctor has his own area, and during his daily period on duty he visits the sick... He may or may not be interested in the whole household and its affairs, but he is certainly not a 'family doctor,' for he undertakes no obstetrics and is not concerned with the children. Moreover, before very long he may move to another place or become a specialist... In the countryside, the pattern is probably more personal. We saw a district hospital where several of the staff have worked for twenty and thirty years or more. The working week of some of them included a 'prophylactic day' when they visited the homes of people who were not ill." (Cut shows medical station of the Lenin Collective Farm in the Ukraine.)

SPECIALTY PRACTICE: "The Russian specialist is by no means necessarily someone whom we would regard as a consultant. In surgery, for instance, there are five grades ranging downwards from the man who is qualified to take charge of a large clinic to the one who is not supposed to operate except in emergency... Some members of our party felt that, in towns as well as in the country, the allocation of specialists to smallish units must seriously damage their efficiency as specialists. The result must be that they tend to work by the book rather than from practical experience."... (Cut shows Moscow surgeons, Academician B. Arkhangelsky and Assistant Professor A. Pokrovsky preparing for an operation.)



CHILD CARE: "In cities the care of children is undertaken by special children's clinics; and, whether the child goes off to a hospital or anywhere else, the clinic remains responsible for him till he is 16." (Cut shows a check-up at a boys' school.)



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REPORT ON SOVIET DOCTORS

... "Clearly such a specialist cannot be sufficient unto himself, and in the Soviet Union he works under supervision. Responsibility for the efficiency of the pediatricians of a region rests on the chief pediatrician of that region: and he exercises authority not only in casual visits but also as chairman of a commission which once a year visits every medical unit in the region. For each pediatrician this commission issues a certificate saving either (1) that the holder is competent to do her job, or (2) that she is competent to do a bigger job, or (3) that she needs further training." (Cut shows a district pediatrician, assigned to a Moscow children's welfare center, making home visit.)



MEDICAL ADMINISTRATION: "In a service where admin-> istration seems to be mainly in the hands of doctors, it is noteworthy that medical administrators-even the deputy ministers of health of the U.S.S.R.-usually work also as clinicians. Medical institutions have lay stewards and finance officers, but these are there as assistants to the medical director." (Cut shows the clinic of the Southwestern Railway near Kiev.)



POST-GRADUATE TRAINING: "Where [a specialist] is found to be deficient in skill or knowledge for the work he is doing, the staff of the institute [governing his specialty] will arrange for him to take a course for some months in one of their hospitals... Many members of the profession were trained at a time when standards were low... and the Soviet authorities thus have particular need to make their post-graduate education easy. But the scheme works less well in some places than in others." (Cut shows advanced study in ENT therapy, conducted by Professor Shcherbatov at the Botkin Hospital in Moscow.)



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REPORT ON SOVIET DOCTORS

DOCTOR'S DAY: "In Russia, as elsewhere, doctors do not always work with one eye on the clock. Officially, however, their working day is only six and a half hours; indeed, for radiologists, psychiatrists, and those in contact with open tuberculosis or other infections, it is less (sometimes only four hours)." (Cut shows Dr. K. Yefremova and radiologist A. Korchmarchik taking a home X-ray.)



PATIENT RELATIONSHIP: "The fact that a doctor is technically an official need not mean that he comports himself continuously as an official. There seems to be kindness and humanity there as here [at home]. 'Do patients take their non-medical troubles to their doctor?' we asked; 'would a woman consult him because her husband drank?' 'What would be the good of that?' was the reply. 'She would go to the authorities of the place where her husband worked, or to the trade union.' In matters of character or worries, how could a doctor help? No difference between British and Russian practice struck me more forcibly than the apparent disinclination of the Russians to accept emotional disturbance as a cause of illness." (Cut shows Dr. A. Anofriev, chief physician of a ball-bearing works clinic, seeing a worker-patient, Gauger Konstantin Smirnov.)





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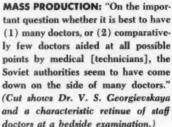
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PAY: "Our hosts were staggered to hear that in [Britain] a general practitioner may earn more than a professor. The basic salary of the young [Soviet] doctor is 660 roubles a month [the rouble is officially quoted at 25 cents; its actual buying power is perhaps 10 cents]. The director of a clinic with a medical staff of forty-five was getting 1,750 roubles, and her district doctors 1,250. (A miner, I was informed, earns 2,000 roubles; and one of our young women interpreters . . . was receiving 1,500). For a doctor of medicine, a professorial chair carries a [monthly] salary of 7,000 roubles." (Cut shows a patient who, judging by his surroundings, is in the Soviet upper bracket. The M.D. is identified only as "Dr. Ustinov.") [MORE >

REPORT ON SOVIET DOCTORS







SUPPLY OF M.D.s: "In Czarist Russia there were about 20,000 doctors, but now there are 300,000. More than half are women, but the proportion seems to have fallen a little. In visiting institutes and hospitals, I fancied that the most senior posts were more often held by men." EDITOR'S NOTE: The population of the U.S.S.R. was estimated, in 1952, to be 207 million. The U.S., with about 162 million people in 1954, then had 218,522 M.D.s. The latest figures (1950) show about 11,000 women doctors in the U.S. (Cut shows a staff meeting at the Botkin Hospital.)

CURRICULUM: "The schools turn out three separate kinds of doctors-the therapeutist, the pediatrician, and the sanitarian. From about half-way through the six-year curriculum, the [last two] get specialized training." (Cut shows medical students in Tajikistan, near the Afghanistan border.)



MEDICAL SCHOOLS: "In 1930 the medical schools were dissociated from the universities and reorganized as part of the State medical service, becoming institutes under the ministry of health. The U.S.S.R. now has sixty-three such institutes... with an output of 20,000-25,000 doctors each year. There seems to be no lack of candidates." (Cut shows candidates submitting entrance examinations at the First Moscow Medical Institute.)

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REPORT ON SOVIET DOCTORS



INTERNESHIP: "Newly qualified [doctors] are likely to be sent for several years to some outlying part of the Soviet Union where few would spontaneously choose to practice. The decision is made by their own medical school; the young doctor goes to a conference in the director or dean's office, where his future is discussed by representatives of various branches of medicine and also with representatives of the enterprises requiring medical aid. An obstetrician is wanted, he is told, in the fish industry; and this will doubtless appeal to him if he is fond of caviar... In remote places, salaries are higher." (Cut shows an "Ambulatory"—traveling dispensary—serving isolated shepherds and cotton farmers in the Tisar mountains, near Afghanistan and Chinese Turkestan. Regular visits are made also to collective farms.)

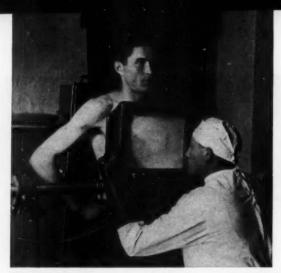




HEALTH RESORTS: "The holiday—especially the holiday under close medical supervision at a health resort—is officially regarded as a powerful means of preventing disease. And the sanatorium, with its clinical investigations, its various forms of physiotherapy, and its detailed regimen, has an important place in the medical system." . . . (Cut shows hydrotherapy at the Institute of Balneotherapeutics in Moscow.)

■ ... "At some 250 health resorts, with 2,000 sanatoriums, about 4 million people were treated in 1953; and much more is in prospect . . . In a country with so many urgent needs . . . it seems extraordinary that anyone should put up such very elaborate and costly buildings when something far cheaper would serve their medical purpose. But in terms of incentives and rewards they may make sense." (Cut shows the Voroshilov Red Army and Navy sanatorium at Sochi on the Black Sea.)

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CHECK-UPS: "They set great store by frequent examination, as a means of spotting disease early, perhaps before the patient is aware of it. There are examinations by a single doctor—the pediatrician attached to a school, the internist who looks after university students, or the district doctor from the nearest clinic. But in addition there are more formal examinations by teams of specialists and special mass examinations for detecting particular diseases . . . If, as I suspect, there are many people who have no strong taste for being examined, they will be hard put to it to escape the net." (Cut shows a routine examination at a rural hospital in Byelorussia.)

ANESTHETICS: "Concentrating on local anesthesia for opera tions, Soviet surgeons have been influenced by the need to devise... methods that can be readily applied by the doctor without special experience—working anywhere between Archangel, Afghanistan, and Alaska. They have achieved such skill that procaine injections suffice them for pneumonectomy, for creating an artificial esophagus, or for removing an intracranial tumor. But neither patient nor surgeon yet enjoys the benefits that recent developments in general anesthesia have conferred on their fellows in the West." (Cut shows minor surgery at a clinic for scientist-patients.)

REPORT ON SOVIET DOCTORS



HOSPITAL SANITATION: "From the moment of arrival the patient is made aware that Pasteur did not live in vain. Hospital laundry must be done on a lavish scale, and we were seldom allowed within sight of a clinical department without putting on white coats or gowns. Often there were masks, too, though these were made from only two layers of gauze. All the hospitals I visited struck me as very clean, and free from smells. In contrast, their lavatories were sometimes unacceptable by British standards." (Cut shows a surgical ward in a new 300-bed hospital for railway workers in Lublino.)

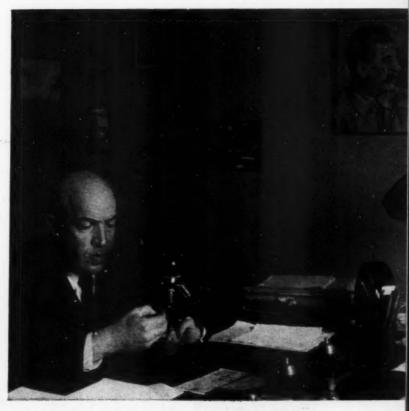
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REPORT ON SOVIET DOCTORS

RURAL AIR SERVICE: "We were told (unofficially) about a young surgeon in a remote place who ran into difficulties while operating under the usual local anesthetic. Explaining to the patient that there would now be an interval, he summoned aid by telephone; and in ninety minutes the regional surgeon had arrived by airplane and was successfully finishing the job." (Cut shows a medical team and plane serving the Borinsk mountain region. The doctor, M. Romanyak, is a deputy to the Supreme Soviet of the U.S.S.R.)





RESEARCH: "Some of the institutes we visited were splendidly equipped, and their staffs were clearly of high quality. But I cannot believe that they will play their full part in the development of medicine until their research workers are able to work without looking over their shoulders. Russian investigators will remain under a grave handicap so long as those who accept Western discoveries or ideas know that they are liable to censure as 'lackeys of bourgeois science' or worse. The Soviet Union . . . will have to choose between science and chauvinism." (Cut shows biologist B. Lavrentiev at the Gorky Institute of Experimental Medicine in Moscow.)

Who Should Own Your Life Insurance Policy?

The answer may surprise you. In many cases it's better, for tax purposes, to have someone else as the legal owner of the policy on your life

By Joseph F. McElligott

• Your life insurance agent (the one who's been urging you for years to buy more coverage) may tell you one of these days that you'd be better off not owning any policies. If he says that, here are two things I'd advise you not to do:

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 \P Don't pat him on the shoulder and advise a sedative or a rest cure;

¶ Don't rush off and cancel all your policies, either.

What he means, as you'll find out by giving him a full hearing, is this: Estate taxes can be cut (or even eliminated) if the person who's insured isn't the owner of the policy on his life. And the 1954 Internal Revenue Code has so changed estate tax law that it's now much simpler to arrange for someone else (such as your wife) to qualify as the legal owner of your insurance policy.

To put the new provision of the law in its proper perspective, let's take a quick look at the general estate tax situation. (Throughout this article, we'll be talking only about *Federal* taxes. States also have estate or inheritance taxes. But they differ so much that we won't discuss them

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here.) Here's a simplified explanation of how Federal estate taxes are assessed:

After your death, the Government will figure out the value of the assets you've left behind. The first \$60,000 you leave will be tax free. But on any amount above that, estate taxes must be paid.

(Actually, if your wife is your major heir, it's possible to arrange your will so that taxes won't begin unless the estate's value exceeds \$120,000. This privilege is known as the marital deduction. By it, you can leave up to one-half of your estate to your wife, free of estate taxes, as long as you specify that she's to receive all the income from it and that she has unrestricted power to dispose of the property as she wishes. If you left \$120,000 to her under those conditions, half would escape taxes under the marital deduction; the other half would go tax free under the basic \$60,000 exemption allowed to all.)

Let's assume you have a life insurance policy that will pay \$50,000 to your wife at your death. Will the Government add this \$50,000 to the rest of your assets when determining a possible estate tax? That depends: If you were the legal owner of the policy, yes; if you weren't the owner, no. That's how the law has always read. But what's new is this: The Government's definition of "owner" has changed.

Under the old tax law you were considered to own a policy on your life if the policy either (1) named you as owner or (2) named someone else as owner but you paid the premiums. It was this payment-of-premiums clause that bothered estate planners before 1954.

Of course, if your wife had independent income, this presented no problem. You simply had her named as the owner of the policy, and she paid the premiums with her own money. When you died, the insurance money wouldn't be added into your estate by the tax men, and

the estate taxes might be cut appreciably.

But suppose—as is more likely—that your wife had no income of her own with which to pay premiums on your life. Then, under the old law, you were just out of luck: The mere fact that you had anted up the premium money made you the legal owner of the policy—even though your wife might protest that the policy named her as owner. So \$50,000 would be tacked on to the value of your estate by the Treasury Department.

The New Law

The new tax law has changed all that: It cuts out the payment-of-premiums test of ownership. So you can now be sure that your insurance money won't be included in your estate (even though you have paid the premiums) as long as someone else is named as legal owner on the policy.

You can easily get the tax benefits of the law for any new policies you take out. (Simply have your wife listed as owner, while you pay the premiums. It's probably best to pay the premiums indirectly, though: Give her the necessary money and let her sign the checks that go to the insurance company.)

Giving Away Policies

But what can you do about your old policies? Consider transferring ownership by giving the policies to someone else. Naturally, before you start giving away assets of such value, you'll do well to talk things over with your lawyer and your insurance company. Otherwise you may end up paying more taxes than before. Here's why:

The policy you give away will be excluded from your estate only if the gift is made under certain specific conditions. For example, the law says that in transferring ownership you must:

No 'Phony' Gifts

¶ Give away the policy completely. It's not enough merely to put your wife's name where yours used to be; you must also renounce all "incidents of ownership." That means you give up your right to (1) borrow on the policy, (2) surrender it for its cash value, and (3) change the beneficiary.

¶ Give away the policy for good. Strange as it may sound, this isn't so easy to do. If there's the faintest theoretical possibility that you could ever regain ownership, then (whether you actually do regain ownership or not) you're considered by law to be still the owner of the policy you gave away.

The law on that point (it's known as "the reversionary interest clause") is extremely complex. Some lawyers feel that it's also inconsistent. So better get detailed information from your insurance adviser before deciding who should be on the receiving end of your gift.

When you're talking things over

with him, you'll find there are a few more points he'll want to bring to your attention. Among them:

Gifts made within three years of your death are presumed by law to have been made "in contemplation of death" (or in plain English, "to escape estate taxes"). So such gifts will be automatically included in your estate unless your executor can prove to the court that you had a valid reason for such largess just before your demise.

The Judge Believed It

But, you may ask, what reason other than contemplation of death could a lawyer dream up when the gift was a life insurance policy? Well, in an actual case, the lawyer for a surgeon's estate argued that the doctor, because of the danger of malpractice suits against himself, had transferred ownership of his insurance policies to his wife to put them beyond the reach of possible judgment creditors. And this argument convinced the court. So, even though the doctor had died shortly after transferring the policies, they weren't included in his estate by the tax men.

Before you decide to imitate that surgeon, though, here are some additional pointers:

Points to Consider

¶ You may have to pay a gift tax when you give away a policy. Gift taxes, though, are lower than estate taxes; and when the gifts are between spouses, such generous exemptions are allowed that the tax, if any, is likely to be small.

¶ If you're not careful, the person to whom you transfer ownership may lose the right (which you, as original owner, had) to decide whether the proceeds shall be paid to the beneficiary in a lump sum or in installments. Your insurance company will probably be glad to revise the policy to eliminate that danger. But be sure to have the contract changed before you actually give it away.

¶ Finally (and this is a big consideration), there's no guarantee that the Government won't revive the payment-of-premiums test of ownership at some future time. On three previous occasions, the Treasury Department eliminated this test and then shifted back to it again. If there's a big loss of estate tax revenue because of the new ease of transterring policies to wives, a future Congress may vote the old test back in again.

If that did happen, and you continued to pay the premiums, then the policies you'd given away would once again become eligible for inclusion in your estate. So you'd be right back where you started. But you wouldn't have lost anything. And you'd have gained this much: For all the years between now and that hypothetical year-of-change, your policies would be safe from estate taxes in the event of your death.



Medical Man in the Moon

By Lawrence C. Goldsmith

Rarely an hour goes by when dermatologist James Q.
 Gant Jr. isn't peering at some sort of skin tissue. Generally, it's human—but quite often it's lunar.

Studying the surface of the moon has been his hobby since boyhood; and he's devoted himself to it so diligently that he's become an international authority on the subject. Not long ago, in fact, he won a form of recognition seldom achieved even by professional astronomers: The British Astronomical Association named a celestial landmark—Lunar Crater Gant—in his honor.

During the ordinary work-week, Dr. Gant practices privately and serves as Chief of Skin and Allergy at the Washington, D.C., Regional Office of the Veterans Administration. Then, on Friday afternoon, he takes off for the Maryland countryside.

His objective: his own observatory, near Boyd, thirty miles outside the capital. There, the heavens' brilliance isn't dulled by the Washington atmosphere; and he and his wife—who serves as his office aide, too—can spend an



HEAVENLY HOBBY of Dr. James Q. Gant Jr. is surveying the surface of the moon. Here he points to the lunar crater named in his honor—a landmark twelve miles across, known formerly as Archimedes-A. Photo on opposite page shows him in a characteristic week-end pose: at his telescope. It's housed in a building constructed especially for it. undisturbed week-end squinting at the moon.

The doctor's lunar specialty is the area known as the Mare Imbrium, where "his" crater is located. He has been mapping this region for thirty-five years now, making quick sketches at his telescope as the sun's reflected rays reveal topographical features in ever-changing perspective. After translating these sketches into more permanent ink drawings, he sends them to the Lunar Section of the British Astronomical Association, which is the clearinghouse for such matters. The association checks the doctor's observations against

those of his colleagues elsewhere on Planet Earth.

Dr. Gant doesn't specialize exclusively in the Mare Imbrium. He has made thousands of sketches of other parts of the moon, too. "I feel really at home there," he says. "So I don't wander around the rest of the heavens much."

What led him to astronomy as a hobby? "It's quite simple," he explains. "When I was a boy just old enough to stay up after dark, I got my first glimpse of the moon's wonders through a spyglass. I wanted to see more of them. I'm still finding things up there to look at."

Functional Arithmetic

 I was wrapping up my instruments after an early morning delivery in the Tennessee backwoods when the father-a young mountain lad-buttonholed me.

"Doc," he said darkly, "how old you figure that young un' is? I ain't been married but four months an' a half."

Over in the corner, the womenfolk were holding their breaths.

"Well," I stalled, "how long has your wife been mar-

"Why-jest the same," he said. "Four months an' a half."

I made a quick leap: "That makes nine months, doesn't it?"

"'Fore God, you're right," he almost shouted, while Grandma joyfully muttered, "Glory be!" and wrapped her arms around her darling daughter.

-PAUL S. WILLIAMS, M.D.

Who Should Control Practice in Hospitals?

That's the question now before the lowa courts. If doctors in that state win their fight to run hospital X-ray and laboratory services, they'll set a precedent for the profession elsewhere

By John R. Lindsey

• First in corn and first in hogs, Iowa is the richest state in the union—in per capita wealth. There's no state debt. There's no state property tax. Most of the farmers own their own land. The state motto reads: "Our liberties we prize and our rights we will maintain."

"We know what our rights are," says Dr. G. V. Caughlan, president of the Iowa State Medical Society. "All we want is that the hospitals understand that they can't encroach on our province, which is the practice of medicine."

The hospitals, too, know what their rights are, says Donald W. Cordes, speaking for the Iowa Hospital Association. "We're not trying to hire surgeons or internists. All we want is to protect our rights to operate our laboratories and X-ray departments as we have done for more than thirty years."

This is not just a dispute between a local medical society and a hospital. It's a full-blown legal controversy over basic principles of physician-hospital relations for the whole State of Iowa. The state Attorney General has already ruled that hospitals are practicing medicine ille-



PHYSICIANS WOULD accept a compromise if it were legal, says Dr. Walter D. Abbott, the Iowa State Medical Society spokesman.

gally by hiring pathologists and radiologists and that the latter are guilty of unprofessional conduct by splitting fees in accepting pay.

The hospitals are challenging this opinion in court. In a counter-claim, the state medical society asks that the opinion be upheld.

Reduced to its simplest terms, the controversy boils down to this:

1. Should doctors operate and control hospital facilities for pathology and radiology, or should lay administrators?

2. Should doctors do the billing for these services and then repay the hospitals for the use of their facilities? Or should the lay administra-

tors do the billing and pay the doctors for their services?

Ranged on one side are the Iowa State Medical Society, the Iowa State Board of Medical Examiners. the Iowa Association of Pathologists, and the state's Attorney General. Ranged on the other side are the Iowa Hospital Association and the state's 172 charitable, nonprofit hospitals.

If the doctors win-and the Attorney General says they're right legally-then the Iowa decision could set a precedent for the medical profession all over the country.

"It would be a pattern other states could copy," says Dr. Caughlan. "It would work like this:

"First, a hospital as a corporation could not practice medicine by hiring pathologists and other specialists. Second, it could not collect and divide fees without informing the patient. Third, here and in other states, each medical society could adopt a code of ethics which would make it unethical for a physician to dispose of his services to any such corporation or nonmedical organization.'

How It Began

How did doctor-hospital relations reach such a point in Iowa? The first hint of the trouble ahead came in 1949, when Blue Cross introduced a new plan known as Comprehensive 70. Worked out in U.S. Steel labormanagement negotiations, the Blue Cross plan provided paid-in-full benefits to patients occupying semiprivate rooms in participating hospitals. Included were such services as X-ray, pathology, and anesthesia, but only if billed for by the hospital, not by the specialist.

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Private physicians charged that these were not hospital services but medical services and that the Blue Cross plan discriminated against M.D.s not classified as hospital employes. Then, in 1952, the Iowa State Medical Society set in motion negotiations to transfer these services to Blue Shield's Iowa Medical Service. In January, 1954, the medical society warned that if progress were not reported soon in the negotiations, it would "support legal action challenging the right of hospitals or corporations to practice medicine."

The dispute erupted publicly a month later, on Feb. 19, 1954. At the request of the Iowa State Board of Medical Examiners, the Attorney General, Leo A. Hoegh (now Governor), ruled that hospitals that hired radiologists and pathologists were illegally practicing medicine and that these specialists themselves were guilty of unprofessional conduct in splitting fees with the hospitals. Whether they were charitable, nonprofit hospitals had nothing to do with the case, the Attorney General ruled.

In the words of the opinion written by Mr. Hoegh:

"We do not intend to say that the mere ownership and operation of a



HOSPITALS WOULD never agree to become just hotels with medical concessions, says Iowa Hospital Association's Donald W. Cordes.

radiology department or pathology laboratory by a corporation in and of itself means that they are engaged in the practice of medicine. Consideration must be given to the hospital for the use of its equipment and facilities, but in our opinion this can be done through a lease arrangement . . . resulting in a true landlord-tenant relationship with freedom of complete independent judgment and operation as the licensed member [the physician in charge] deems best.

"Such an arrangement would permit the physician in charge of the department to be directly responsible to the patient and make possible the paying of the fee for professional services direct to that physician."

The Iowa Hospital Association immediately challenged this opinion. Said its attorney, Allan A. Herrick:

"We've no choice but to oppose any change that narrows the hospital's function to that of a hotel."

The association declared: "The pathologist—as well as the radiologist—does not diagnose disease; he does not administer treatment. These functions are the responsibility of the patient's personal physician."

That may be so, replied the medical society; but "all radiology and pathology services contribute to the diagnosis and treatment of diseases



"MEDICAL PRACTICE—Free or Hospital-Controlled?" is the issue in Iowa, as presented in pamphlets like these circulated by the state medical society.

and every facet of this work constitutes the practice of medicine."

The medical society has insisted that fees for pathological and radiological services in the hospital be billed in the name of the specialist in charge, although the hospital may act as collection agent for him.

In the Doctor's Name

If this were done, the physician would then make a "fair and reasonable allocation of the fees" to the hospital for its facilities, employes, and general operating expenses. This would meet the requirements of the law, said the Attorney General in a supplementary opinion last Nov. 8.

At that time, he also upheld the medical society's demand that the following language be inserted in hospital admission agreements:

"Pathological and radiological services are medical services performed and supervised by physicians, and the facilities are furnished by the hospital . . . I [the patient] request that the fees for the pathological services and facilities shall be made in one bill in the name of the doctor and consent that an allocation of the fees may be made by the doctor to the hospital."

The hospital association has balked at this. Its president, Louis B. Blair, administrator of St. Luke's Hospital in Cedar Rapids, says, "The only apparent reason for this clause is to have the hospitals admit in writing something they do not in fact believe. We don't agree that everything relating to the laboratory or X-ray department constitutes the practice of medicine."

The Hospitals' View

Speaking for Iowa's 172 charitable, nonprofit hospitals, Mr. Cordes, also a hospital administrator, says:

"We can't accept the Attorney General's opinion for three good reasons:

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"First, we'd be literally forcing millions of dollars in laboratory fees from hundreds of thousands of Iowans to pass through the hands of thirty-one pathologists [the total number of pathologists in Iowa].

"Second, we'd be forcing about a million and a half Blue Cross members to give up insurance coverage for laboratory services.

"Third, we'd be reducing hospitals to the status of hotels having medical concessions."

Cordes adds: "The hospital trustees cannot agree that all work done under the direction of a physician automatically becomes the practice of medicine. While it is agreed that everything done for a patient is, and should be, under the attending physician's direction, not everything done in the hospital can be considered the practice of medicine."

The Lawsuit

In their court petition, the hospitals state that no question has been raised about the quality of the hospitals' laboratory services. The petition says: "The sole issues in the controversy involve the method and manner of maintaining and operating laboratory facilities . . . and the method and manner of compensat-

ing physicians."

The petition emphasizes that each of the hospitals involved is a charitable, nonprofit corporation and that no individual "profits" from the operation of laboratory services. The hospital administrators say their suit is not vindictive or punitive, but aimed only at clarifying their legal rights.

Points at Issue

The petition asks the court to rule along these lines:

 That the ownership, operation, and maintenance of laboratory facilities are an integral part of the lawful activities of a hospital and that hospitals may charge and bill for laboratory services, just as they have done as long as hospital facilities have existed in Iowa.

2. That nonprofit, charitable hospitals have the right to employ pathologists as heads of their laboratory facilities under the same terms as they are now and always have

been employed.

3. That the Iowa State Board of Medical Examiners and its members and the Iowa Association of Pathologists and its officers be restrained and enjoined from interfering with hospital-employed pathologists in carrying out their legal contracts with the hospitals. [MORE▶

 That the board and the association be stopped from interfering with the hospitals in their operation of their laboratories.

The hospitals say they did not name the state medical society "because the hospitals feel that the demands made by a small group of pathologists do not represent the views of the great majority of doctors in Iowa."

Conspiracy Charged

The hospitals charged conspiracy on the part of the medical examiners and the pathologists' association on grounds that they "have threatened various hospitals with the loss of pathological and radiological services unless the hospitals enter into written contracts with the medical specialists giving them the right to make charges for all laboratory or X-ray services rendered and to bill for the same."

Attorney General Dayton Countryman is named as a defendant in his official capacity, but the petition adds: "The Attorney General in no way has been a party to said conspiracy." Mr. Countryman succeeded in office Governor Hoegh, who wrote the original opinion.

The petition charges further attempts "to force the hospitals to turn over absolutely to the medical specialists the control of an integral part of their facilities which represents millions of dollars in buildings and equipment which have been supplied by private gifts and public appropriations and which have been entrusted by the public to the unpaid governing boards of the hospitals."

In their counter-claim, the medical examiners, the pathologists, and the Attorney General ask the court to rule that the hospitals are illegally practicing medicine in their conduct of the X-ray departments, as well as the laboratories, in line with the Attorney General's original opinion.

Although not a defendant, the Iowa State Medical Society has filed a petition of intervention, endorsing the defendants' position and asking the court to find that the hospitals "are selling to the public"—in the form of laboratory and X-ray services—"diagnostic and treatment services for human injury and disease" and are thus "engaged in the unauthorized, unlicensed, and illegal practice of medicine."

The hospitals charge that the Attorney General's opinion did not take into account certain provisions of the law and that he "totally ignored the customs and practices developed in hospitals relating to the operation and maintenance of laboratory facilities."

Connecticut Ruling

Hospital spokesmen point out that Mr. Hoegh's interpretation of the law is not shared by all other states. In Connecticut, for example, the Attorney General ruled last December that "nonprofit, charitable hospitals are not violating [MORE ON 288]

Competition in Medical Practice Today

This four-year, 8,000-interview study of a reportedly typical American community shows that professional rivalry, when carried to excess, isn't just a knife in the back; it's hara-kiri

By Helen C. Milius

• Competition is a word that well-bred medical men sometimes hesitate to apply to their own profession. But it is now applied bluntly in the report of an investigation sponsored by the Commonwealth Fund.

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A task force of social scientists, headed by Dr. (of philosophy) Earl Lomon Koos, made a four-year study of health problems in what's described as an average American town. Koos calls the town "Regionville."

His report pictures Regionville's physicians as locked in an economic struggle so intense that their leftover energies allow them to be "only partially effective in meeting the health needs" of their patients. It also shows, significantly, that the doctors' rivalry derives almost entirely from their own compulsive attitude and not at all from their working conditions (e.g., professional overcrowding or financial pressure).

Koos, a professor of social welfare at Florida State University, instructed his investigators to observe, analyze,

^{6&}quot;The Health of Regionville: What People Thought and Did About It," by Earl Lomon Koos, Columbia University Press, New York. 1954. 177 pages. \$3.25

and report with dispassion, but not to criticize or condemn." Their findings, therefore, shed a relatively cool, white light on such questions as:

¶ What causes excessive medical competition?

¶ Who gets hurt by it?

¶ How can a doctor hold his own against it?

¶ How can he climb out of the competitive rut?

Another 'Middletown'

Koos chose Regionville in much the same way that Robert S. and Helen M. Lynd, for their classic sociologic study, chose "Middletown." Each community is intended to represent "America in microcosm."

Koos' Regionville is actually a small hill-country community in an Eastern farm area. It has a stable population of about 11,000; average job opportunities; an unaccredited hospital; the usual pretentious little bank; and unpretentious gas stations, old stores, and frame houses. It's served by five doctors, five dentists, a pharmacist, a public health nurse, and a chiropractor.

Koos stumbled on the hard fact of professional competition accidentally. For it was Regionville's patients, not its physicians, that he and his research team set out to study. He was after "what makes people behave as they do in regard to health and illness."

Koos' researchers interviewed 514 families, a balanced 20 per cent

sample. What's more, over the fouryear period of the study, they interviewed each family sixteen times.

It might have been expected that in these more than 8,000 conversations about their health problems, the townspeople would have plenty to say about their doctors. And they did. But quite unexpected was what their comments revealed about local professional rivalry.

The mosaic of patients' remarks constructed by Koos shows two pushers among Regionville's M.D.s; one man at the peak; and two losers, their practices petering out:

¶ Dr. V is a go-getter on the way up. He already has the area's third-largest practice. He's known for "shuttling patients through his office" and for being businesslike in his billing methods. People say he's "hospital happy . . . like a big-city doctor." He's the only physician in town whose "good equipment" gets talked about. He and his wife are well in the social swim.

¶ Dr. W has the second-largest practice, and is also pushing hard. He accommodates his patients with a willingness "to make home calls even in the middle of winter and the dead of night" and by dispensing medicines. He's sometimes called the "farmers' doctor."

¶ Dr. X is the top man now, with the largest practice. He has a reputation for being a "good doctor" with "sound medical knowledge." He kicks at making house calls, and gets away with it.



MEDICAL RIVALRY, says sociologist Earl L. Koos, results from the failure of many physicians to understand the social implications of their role in the community. Koos' study was financed by the Commonwealth Fund.

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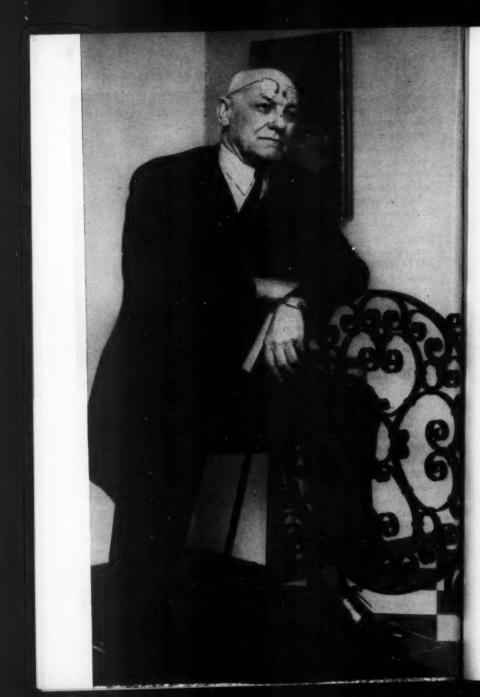
¶ Dr. Y's dwindling practice is second-smallest. Of the five local M.D.s. he's said to be "the most available." Patients like him for his unhurried visits, his low fees, and his low-pressure collection methods. He dispenses medicines and shows a "willingness to fit both diagnosis and treatment to the expectations of his patients (if Mrs. F wants pills, she's given pills-if only placebos)."

¶ Old Dr. Z is losing out too; but he makes no compromises. Some patients are loyal to him because they've had him since childhood.

Nevertheless, his remaining practice is the smallest. He's regarded as the most lenient about bills.

Koos tried to discover what qualities enable a doctor to keep patients coming to him despite the counterattractions of his rivals. These qualities vary, he found, because the standards and tastes of the patient vary with his social class.

Like any other American town, Regionville is keenly conscious of class distinctions. It rates a man by his income, occupation, and living standards. MORE ON 269]



How Doctors Can Cope With Criticism

'Let's not criticize people for criticizing us,' says the incoming president of the A.M.A. In this article, prepared expressly for MEDICAL ECONOMICS, he tells some things he's learned as a result of complaints from the public

By Elmer Hess, M.D.

• Sitting on my desk at this moment are three thick folders, each one bulging with hundreds of letters from people I don't know.

These letters have come from all over the country; they've been written to me simply because I'm currently an officer of the American Medical Association. The significant thing about these letters is that most of them register complaints.

What sort of complaints? Well, just look over my shoulder while I leaf through a representative sampling:

Here's a letter from a man in Yonkers, N.Y., complaining about doctors' slowness in handling his workmen's compensation claim. Here's another from a nurse in Washington, D.C., protesting the treatment her brother got from Government physicians. Here's one from a Pittsburgh woman objecting to charity-clinic procedure. And here are three letters complaining about individual physi-

THE AUTHOR, a wrologist in Erie, Pa., takes office next month as the one hundred and ninth president of the American Medical Association.

cians: alleged negligence in Philadelphia; alleged indifference in Pasadena, Calif.; alleged overcharging in Wausau, Wis.

During the past year, I must have received more than a thousand complaints along these lines. In every possible case, I've asked the local medical society to investigate. And in the vast majority of cases, the report has come back to me: "Complaint not warranted!"

Misunderstandings, rather than medical misdeeds, have been the root of the trouble.

But let's not criticize people for criticizing us. The fact is, we can learn from their complaints-yes, even when their complaints turn out to be groundless.

Two lessons in particular rise out of the letters I've received, and I'd like to pass them along to you:

Publicity Problem

1. Collectively, we need to be less cautious about publicizing our mediation machinery.

In December, 1949, the A.M.A. House of Delegates urged all constituent medical societies to set up grievance committees. At the time, only twenty-nine such societies had them. Today grievance committees exist in all our state medical associations, and in some 700 county societies besides.

But do patients know about them? After spot-checking 182 county societies, the A.M.A. Council on Medical Service concluded:

"An informed public does not seem to be a reality, since 109 counties . . . report that the public was not given complete information on how to use the committee. Further, approximately 77 per cent report that continued publicity has not been employed . . . The public can make little use of a service if it does not know that the service exists."

Well-Kept Secret

It's sometimes said that "publicity would only invite trouble and encourage ill-founded complaints." As a matter of fact, we used to feel this way in my home county of Erie, Pa.

The only people we told about our grievance committee in its first year were lawyers, aldermen, and other officials who might be able to refer doctor-patient disputes to us. Our grievance committee handled only four cases that year.

Then suddenly we realized that this didn't make sense. Here we were, in a city of 140,000, getting only four complaints annually. Probably many more misunderstandings existed. Each one we neglected could develop into damaging gossip, malicious rumor, or malpractice litigation.

Who Got Hurt?

Thus, by not publicizing our mediation machinery, we local doctors were hurting ourselves.

Today in Erie our grievance committee is advertised, written up in feature stories, even mentioned on television. It handles ten times as many cases as before—and therefore does ten times as much good.

Sure, a few odd complaints come in. But isn't it just as important to clear up this kind as any other? I think so—and I can speak from personal experience:

It Happened to Him

Not long ago, I did a urological reconstruction on a young man. Afterwards, he didn't get along too well in a six-bed ward, and I felt psychiatric treatment was indicated. When his mother heard about it, she hit the roof. She refused to pay the psychiatrist's bill or mine; and she registered a complaint with our grievance committee.

It seems entirely wholesome to me that this woman knows about our grievance committee and can get a fair hearing from it. I'm prepared to accept my colleagues' recommendation in the case. Only in this way, it seems to me, can both the public and the profession be protected.

What, then, can be said about the thousand-odd people who sent their written complaints to me? Obviously, they didn't know they could get fair hearings in their own home counties. They should know. And so, in my opinion, should the public at large.

 Individually, we need to be more cautious about collecting disputed bills.

As I've said, the vast majority of complaints I've received have

turned out to be unwarranted. But something stirred these letterwriters up. Something made them angry enough to pour out their troubles to a stranger in a distant city. What was it?

I've looked through the thousand-odd letters in search of the answer. A surprising number of them show this pattern: The patient wasn't quite satisfied with the doctor's services—and then the physician pressed too hard to collect his fee.

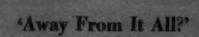
This case in point comes to mind: A woman patient went into the hospital to have a small cyst removed. A few days after she returned home, she began to bleed. In a panic, she phoned the surgeon and asked him to come right away. "You come down to my office instead," he told her.

She Had to Wait

When she arrived, the surgeon made the woman wait her turn. He did this because he realized that her bleeding wasn't serious. But *she* didn't realize it; and nothing he could say later seemed to satisfy her.

She ignored his bill for many months. Finally he took it to a small claims court. And then—only then—she filed a complaint against him with the local grievance committee.

I don't know what that grievance committee decided. But I do know what the surgeon himself undoubtedly decided: that collecting this particular \$25 bill [MORE ON 267]



A vacation play in three acts: Act 1-The Drown; Act 11-The Reality (more anguish than languish); Act 111-The Conclusion (there's no place like home).



Starting to Relax



Backeche Barrage

Modical History a la Carte Bloody Ness, Poison lay, and

Scratch Brigade

What's Good for a Hangaver, Dector?"





Who Owes the Doctor After an Auto Accident?



These eight examples indicate when you can, and cannot, expect an insurance company to foot the medical bill of an accident victim

By George G. Coughlin and Joseph J. Schneider

• Fewer doctors' bills would go unpaid if more physicians and patients understood accident claims and car insurance. Many an M.D. discounts bills, or writes them off entirely when there is no need to. The patient, meanwhile, may have ideas about his claim that are just as erroneous.

Yet you don't have to be a Supreme Court judge to be able to figure out what accident claims are likely to be paid. In most cases, all you need is a basic knowledge of two types of car insurance and claims: (1) "medical-payments" and (2) liability.

Medical-payments insurance pays all reasonable medical and surgical expenses incurred within one year by each person covered who is accidentally injured "while in or upon, entering or alighting from" a car. This is a relatively new form of coverage and it's proving to be a boon to physicians. It has nothing to do with negligence. The insured can collect for his medical expenses even though he is responsible for the accident.

Liability insurance, on the other hand, takes care only of those claims that the insured becomes "legally obligated to pay." It does not pay automatically, the way medical-payments insurance does. If your patient's at fault in an accident, his chances of collecting on a liability policy to satisfy your bill are slim.

Let's take a look now at some examples culled from a good many years' experience with automobile accident claims. These cases illustrate some of the collection

THE AUTHORS of this article collaborated also on "You and Your Car Insurance," which they say is "the only book on auto accident claims addressed to the car owner." Mr. Coughlin is a Binghamton, N.Y., attorney who has been handling automobile accident cases for twenty-five years. Mr. Schneider is an insurance claims manager in Binghamton.

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problems a physician who treats smashup victims is likely to face. First, some *medical-payments* cases:

Example 1. Accident caused by patient's negligence:

Fred Albright drank one too many at a cocktail party. The road on the way home curved, but his car didn't.

He wound up lying in a hospital bed and owing \$600 to the surgeon who attended him. He has a \$2,000 medical-payments policy.

QUESTION: Will the insurance company pay the bill, even though Albright was obviously drunk and entirely to blame for the accident?

ANSWER: Yes. A medical-payments policy disregards questions of liability and negligence.

Example 2. Patient injured getting into a car:

Paul Barton stopped his car to give his neighbor's wife, Alice Aker, a lift home from the store. As she was setting her bundle of groceries on the rear seat, the door of the automobile accidentally slammed on her hand.

Several operations were necessary. Her doctor's bills amounted to \$350. Barton has \$500 of medical-payments coverage. Mrs. Aker, however, does not have insurance of any kind.

QUESTION: Will the insurance satisfy the surgical bill, despite the fact that Mrs. Aker carries no insurance herself? ANSWER: Yes. Barton's policy covers any person injured "in or upon, entering or alighting from" his car. Mrs. Aker was clearly in the car or in the act of entering it.

Example 3. Multiple claims arising from the same accident:

William Spinney's car skidded into a phone pole. Spinney escaped injury; but his wife, his daughter Jane, and a neighbor's child, who were riding with him, were all hurt.

The doctor's bills totaled \$300 for Mrs. Spinney, \$400 for Jane, and \$500 for the neighbor's child. Spinney has a \$500 medical-payments policy.

QUESTION: Is the physician who treated them likely to collect the \$1,200 due him on Mr. Spinney's \$500 policy?

ANSWER: Yes. The full amount of the policy applies separately to each person injured in the car. So each may collect up to \$500.

Example 4. Patient injured in an uninsured car:

Gordon Davis, who had neglected to renew his car insurance, offered Harry Meyer and his wife a ride. Meyer has medical-payments coverage on his own car, but it was Davis' car that cracked up.

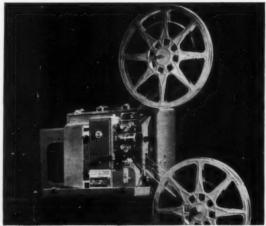
Both the Meyers were injured. Their own physician treated them.

QUESTION: Will the insurance company pay the doctor's bill for the Meyers' injuries, even though



Tattoo, right cornea

If the case is worth filming...



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5 mg. (1/12 gr.)

Each NEOCYLATE with CORTISONE Entab contains: Aminonium Salicylate 0.25 Gm. (4 gr.) Potassium Para-Aminobenzoate 0.32 Gm. (5 gr.) Ascorbic Acid 20 mg. (1/3 gr.)

RECOMMENDED DONAGE: For acute cases, 8 to 10 Entabs daily in divided doses. For maintengage, I or 2 Entabs four times daily. SUPPLIED: Battles of 50, 100, and 200 Entabs (enteric-coated tablets).



Literature on request

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Cortisone Acetate

they were hurt while riding in an uninsured car?

ANSWER: Yes. Meyer's policy covers him and his wife for injuries suffered in their car or in anyone else's. It wouldn't have covered Davis' medical expenses of course, if he had been injured.

Example 5. Time limit on medical expenses:

Frances Day injured her nose in an automobile accident. She went to her doctor immediately for treatment of the wound. Later she needed plastic surgery. But the operation was delayed a year and a half.

The doctor's bill at the time of the accident was \$25. For the plastic surgery a specialist charged \$400. Miss Day has medical-payments coverage of \$1,500.

QUESTION: Can the plastic surgeon look to the insurance company for his \$400 fee?

ANSWER: No. The company will pay for Miss Day's \$25 treatment but will not finance the plastic surgery. Its contract commits it only to pay "reasonable expenses incurred within one year from the date of the accident." Once the year is up, the patient must pay.

Now here are a few case histories of *liability* claims:

Example 6. Two-car accident; both injured drivers at fault:

George Edison and Marvin Fish collided at an intersection. Each was

driving his own car. Both were injured and required medical attention. They were equally to blame and admitted it. Each carried liability insurance.

QUESTION: Can Edison collect from Fish's insurance company, and Fish from Edison's, to pay the doctor?

ANSWER: No. Neither company will pay because both men were at fault.

Liability insurance companies don't pay all claims. As already noted, they agree to pay only those for which the assured becomes "legally obligated." In this case, neither one is.

Example 7. Questionable liability for a claim:

John Grogan rammed the rear of the car ahead of him in a line of holiday traffic. He was injured when his head hit the dashboard. A physician treated him.

Each driver had liability insurance. Each also had his own explanation of the cause of the accident.

Grogan claimed the car ahead of him stopped suddenly. The other driver (with whom witnesses agreed) said that he'd been stopped for several seconds before the accident occurred and that Grogan appeared not to have his car under control.

QUESTION: Who'll pay the doctor's bill?

ANSWER: Probably Grogan, out of his own pocket. There's an axiom

"Good Response"

in psoriasis 79%

of cases treated with Entozyme alone

After using digestive enzyme replacement with ENTOZYME Robins' as the only therapy in a series of 24 peoriasis patients "recalcitrant to all previous tribatment," Ingels' reports that "good response occurred in 19 cases [79%] within four weeks to three months . . . complete clearing in four ceses."

Entozyma provides pancreatic emzymes to help restore normal metobolism, so commonly disordered in the peorlatic ... and thus represents an effective systemic approach to successful therapy.

Pingels, A. H.: Collienia Medicine 29-(17, 1951.



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'tablet-within-a-tablet' contains:
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coating . Papin, N.F. 250 mg.
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Robins

ENTOZYME

Estical Pharmacoulous of Morit effice 1871

that says, "Questionable liability means questionable payment." And Grogan's case certainly looks questionable.

So the doctor had best bill his patient direct and send a copy of his bill to the insurance company. Legally, it's the patient anyway—not the insurance company—who's liable for the doctor's bill.

Example 8. Protecting the bill for professional services:

Corporal Frank Huff, U.S.A., was home on furlough. He took his family out for a Sunday spin. A careless driver ignored a stop sign and piled into Huff's car broadside. Huff, his wife, and two children were all injured and had to have immediate medical attention.

Settlement of the liability claim against the reckless driver has been

delayed. Huff has no money of his own to pay the doctor's bill.

QUESTION: What steps can the physician take to help assure payment of the bill owed him by Huff?

ANSWER: He can ask the insurance company to add his name to the settlement draft. He should do this immediately, since there is every likelihood that Huff's claim will be paid.

Insurance companies are glad to protect the doctor's bill; some do it automatically; others, only on request. Whenever you think a patient may not be financially responsible, send a copy of your bill to the insurance company, with a notation on it like this:

"Please protect my bill in the event a settlement is made."

You'll be surprised at how often this pays off.

Better Than Elephants

• I was just out of medical school, and winding things up after my first delivery. The young father looked ill at ease as he asked my fee.

"Ten dollars," I said. (That was thirty years ago.)

"Well," he replied with a frown, "you may have to take it out in trade."

"Oh, that's all right," I nodded affably, not thinking to ask his business.

Next day I found out when I saw the clutter on my desk and the swarm of fruit flies above: He was a banana-vendor.

-LOUIS A. DOROFF, M.D.



What's Your Best Buy

This panoramic view of the malpractice market suggests that premium rates aren't the only thing to think about. Consider also the screening of risks, the prevention of claims, the fighting of suits, the limits of coverage, the type of contract, and the type of carrier

By R. Cragin Lewis

• Just a few months before he left for the White House, Abraham Lincoln defended the first doctor ever brought to trial for malpractice in Illinois. It was a fracture case that had turned out poorly; some deformity had resulted. Other doctors testified that the splints had been improperly applied.

Lincoln's physician-client had to pay \$700 in damages.

Not long ago in California, there was a remarkably similar case. The plaintiff's fractured arm hadn't mended as it should have; it was now half an inch shorter than before. "Lack of proper attention" was ascribed to the attending physician.

This time the court set the damages at \$8,500.

How do you account for the difference? What's the real reason for inflated malpractice awards? Well, money

in Malpractice Insurance?

values have changed since Lincoln's day; and human values have changed even more.

People used not to put price tags on priceless things. The year after Lincoln's malpractice case, for example, a New York court declined to award \$1,500 to the parents of a child who had died. In setting aside the jury's verdict, the judge commented as follows:

"The child was four years and one month old when he died. For the next ten years—had he lived—it may safely be said that he would have been a burden in place of a benefit, pecuniarily, to his parents. And for the next seven years after that, if educated to a profession or mercantile calling or put to a trade, he would have done well—much better than the majority of lads— if he supported himself. During all this time, he would be exposed to disease and death and other ills...

"The life of this little boy, however priceless may have been its value in other aspects, had no pecuniary value which the jury could justly estimate at \$1,500. If the plaintiff recovered at all, the damage should have been nominal..."

Today, however, that quaint word "priceless" has all but vanished from the legal lexicon. Nothing is of inestimable worth: even ten minutes of "conscious suffering" can be given a precise dollar value—so the current theory goes.

[MORE]

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In powder form—readily and completely dissolves in milk and milk formulas without affecting taste, odor or color.

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Kanilworth, New Jersey

A TYPICAL CASE RESPONSE

(Carol, age 13 months . . . 5 pounds underweight)

18 BODY WEIGHT 17 16

WEEKLY PROTEIN INTAKE (grams)

200 207 100 107 272 207 200 277 20

Chart shows marked effect of supplemental lysine on body weight and blood proteins of underweight child, who because of aversion to solid foods was fed milk formula reinforced with milk protein preparations. Adequate amounts of multiple vitamins (including vitamin B12) were administered during both control and lysine-supplement

periods. High protein and high caloric diet was without effect except for reducing appetite of the child. It was only when supplemental lysine was added to this diet that prompt appetite improvement and better utilization of dietary protein occurred. When lysine supplementation was discontinued, nutritional regression occurred.

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Lactofort is indicated for use in the nutritional management of pediatric patients with poor appetite and subnormal body weight due to a variety of causes such as in the premature infant - gastrointestinal disturbances - infection - allergy and other factors that lead to chronic impairment of food intake, absorption or utilization.

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- Albanese, A. A., Higgons, R. A., Hyde, G. M. and Orio, L.: Biochemseal and Nutritional effects of Lyaine Reinforced Diets, Am. J. Clin. Nutrition Vol. 3, (Max.-Apr.) 1935
 Food and Nutrition Board, National Research Council. Publ. \$508.
 Recommended Dietary Albouences Revised 1955, Washington, D. C.

MALPRACTICE INSURANCE

Liability lawyers have pushed this new idea vigorously. (Why not? Their fees are contingent on court awards.) And too often, judges and juries have been swept along.

Off the Gold Standard

What are physicians up against now? "We must recognize," says Dr. James Basil Hall, "that the human commodity we deal with has, on several recent occasions, been declared more precious than gold, ounce for ounce."

Dr. Hall, an imaginative researcher from Mount Dora, Fla., reviewed all the malpractice awards he could find reported over the last five years.

He corresponded with court clerks and legal authorities throughout the country. He sums up the lesson he learned in these striking terms:

"Gold is officially valued at \$35 an ounce. But a baby fatally injured in a delivery-room accident in Washington, D.C., has been officially valued at \$150 an ounce. A Memphis youngster, burned during circumcision, has been valued at \$220 an ounce.

"Adult patients, too, have lately been adjudged to be worth more than their weight in gold. These include an Oklahoman who suffered partial paralysis following spinal anesthesia; a San Franciscan who re-



"The one with the fly in it."

when prescribing a diaphragm

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ly re n-ed n-e-





Ontho Kit



Reception

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PRECEPTIN

quired radical surgery because his cancer had previously been treated as a 'venereal wart'; and a Nashville patient who lost her vision when she fell out of bed while under the influence of drugs."

All three of these patients survived their misfortunes, Dr. Hall reports. And all three were awarded damages ranging from \$85,000 up.

"Since 150 pounds of solid gold are worth only \$84,000," he comments, "it seems fair to conclude that we've left the gold standard behind."

Carriers Getting Out

Exceptional cases? Of course they are. Your chance of getting caught up in any such suit is still far less than your chance of being knocked off in an auto accident. But here's what hurts:

You can easily insure yourself against auto accidents. You can easily insure yourself against most other hazards nowadays. But professional liability is in a class by itself: You're confronted with a dwindling choice of policies at steadily rising rates.

Before the present claims-conscious era, well over 100 different companies wrote malpractice insurance. They not only wrote it; they actively solicited the doctor's business.

Today the companies that are still in the field number no more than sixty. Few of them solicit business, and many won't write new policies. Even the group purchasing power of physicians, when brought into play, hasn't altered this trend. The American College of Radiology had a group malpractice plan for its members; but in 1953, its underwriter decided not to continue it. The same thing happened to the Connecticut State Medical Society.

Just recently, the American Academy of General Practice approached nearly fifty underwriters (including some abroad) in an attempt to start a new group malpractice plan. All the companies declined the business. They just weren't interested in making the rate concessions you'd expect under such a plan.

The American College of Surgeons has also been trying to set up a new group plan. According to Dr. Paul R. Hawley, director of the College, surgeons are presently insured by some twenty different companies.

These twenty companies probably represent the hard core of the malpractice insurance industry to-day—the carriers with enough experience to keep their losses under control, even in a high-risk specialty.

And how have they kept losses under control? Through frequent hikes in premium rates.

Rates Still Rising

Ten years ago, surgeons insured through the New York State medical society's group malpractice plan paid \$30 a year for minimum coverage. This year, for the same coverage, they must pay \$226 in the New



"Unfortunately," writes Dr. B. Wheeler Jenkins, "with most orally administered drugs, the minimum dose is three a day, which is about two doses too many for the average patient to remember."

But patients can remember one dose a day

To overcome patients' forgetfulness, Dr. Jenkins suggests 'Spansule' sustained release capsules because "they can be prescribed for the one period of the day that is free of distraction and controlled completely by routine—the period before breakfast"

See the following pages for information on medication now available in

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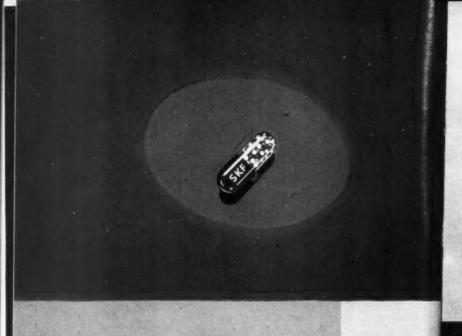


important: 'Spansule' capsules are made only by Smith, Kline & French Laboratories, Philadelphia—the originators of sustained release oral medication—and every capsule bears the monogram "SKF".

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1. GP 9(6):66 (June) 1954.





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In 2 dosage strengths:

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No. 2 (2 dots on capsule)—'Dexedrine' Sulfate (dextroamphetamine sulfate, S.K.F.), 15 mg.; amobarbital, 1½ gr.

Both dosage strengths have the same duration of effect; they differ only in intensity of effect.

*T.M. Reg. U.S. Pat. Off.

Patent Applied For.

†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.



for day-long control of appetite in weight reduction

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brand of sustained release capsules

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10 mg. (1 dot on capsule) and 15 mg. (2 dots on capsule)

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0.8 mg. (2 dots on capsule) selected belladonna alkaloids

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effect;

belladonna alkaloids plus phenobarbital

Spengulat

brand of sustained release capsules

anticholinergic (antisecretory and antispasmodic) plus sedative

0.4 mg. belladonna alkaloids plus 1 gr. phenobarbital

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Spansule*

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In 2 dosage strengths:

8 mg. (1 dot on capsule) especially for younger children and 12 mg. (2 dots on capsule) for adults

Both dosage strengths have the same duration of effect; they differ only in intensity of effect.

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Smith, Kline & French Laboratories, Philadelphia the originators of sustained release oral medication





York City area and \$119 outside it.

On the opposite coast, doctors insured under the Alameda-Contra Costa group plan have seen their premiums jump 40 per cent in the last year alone. Throughout the country, doctors insured individually by the big stock insurance companies are paying an average of 35 per cent more this year.

These leapfrogging rates have made some men cry, "Profiteering!" But the carriers are not noticeably getting rich on malpractice insurance. Nearly all have had some redink years recently—even in "lowrisk" areas. (Two years ago, the Indiana medical society's group plan reported \$48,000 in premiums, \$70,000 in losses.)

The truth is, doctors pretty much create their own malpractice premiums. They can push them higher, for example, by overinsuring themselves or by permitting nuisance settlements. They can hold premiums down by banding together with the best risks and by working to prevent claims.

Your best buy in malpractice insurance, therefore, can't be measured by present premiums alone.

The long-term protection you want—the best legal, financial, and public relations protection your dollars can buy—may be found in the cheapest plan available; or it may be found in the most expensive plan. Here are the factors you'll want to check:

1. The Screening of Risks

One carrier regularly turns down about 15 per cent of the doctors who apply for malpractice coverage. Although it checks each man individually, it generally won't accept plastic surgeons, orthopedic surgeons, X-ray therapists, electroshock therapists, and doctors in certain claimsconscious neighborhoods.

That's tough on the doctors excluded. But it's good for everyone else. If you're a typical practitioner, you don't want to pay for risks any worse than your own.

Even a doctor's attitude can make

him a bad risk, another carrier has found. It cites the case of a Pennsylvania physician who loudly criticized a colleague in court. He brushed aside the complications his colleague had faced and said: "Poor results speak for themselves!" But more experienced doctors disagreed with him—and so did the jury.

Suspecting trouble, the carrier canceled the man's malpractice policy. And sure enough: He's now being sued by a patient largely because of his attitude. The doctor allegedly resisted consultation for

for "This Wormy World"



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Antepar' is well-tolerated and pleasant to take.

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three weeks while his patient was developing a permanently stiff knee.

Group malpractice plans have trouble screening out such risks. At least one group plan, in fact, was started by specialists who couldn't get coverage on an individual basis. For years all doctors in the plan were charged the same flat rate. That meant typical doctors were paying for atypical risks.

Now, belatedly, group plans are beginning to vary premiums in accordance with risks. Coverage for operative obstetrics now costs more than coverage for uncomplicated obstetrics. There are different prices for deep X-ray therapy and superficial X-ray therapy.

Crown plane are also

Group plans are also beginning to realize that rescaled rates aren't enough:

"Raising our rates from year to

year is no cure," the New York group plan reported recently. "Thousands of fine, competent members of the society have never been threatened with a claim or suit... They, however, are the ones who are made to suffer... by a few hundred doctors in their midst... [We must] eliminate those who are responsible for our plight!"

Look around for the malpractice plan that does the most to "eliminate those responsible." It may be the

best one for you.

Of course, poor risks aren't the only problem. As Dr. Louis J. Regan points out, "the majority of [malpractice] actions involve practitioners who are above the median of their respective groups in experience, standing, and reputation." That brings us to the next checkpoint:

2. The Prevention of Claims

Don't switch malpractice plans before comparing what they do to prevent claims. "Prevention . . . holds more promise than any solution offered thus far," Theodore Wiprud reported recently from Washington, D.C., where claims have leveled off somewhat after quadrupling since 1940.

Prevention means making doctors conscious of what causes claims. A prime cause is "careless statements by some physicians about their colleagues and their professional skill." Mr. Wiprud estimates that 25 to 30 per cent of all claims filed in Washington arise from such criticisms.

Elsewhere it's estimated that another 25 per cent of recent claims have been generated by "members who sued dissatisfied patients to collect their fees before the statute of limitations had expired for a malpractice suit."

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produces excellent belladonna
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fractional doses
of belladonna and
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THE ARMOUR SABORATORIES

Which suggests that malpractice claims could be cut in half by forcefully reminding doctors of these things. Does your malpractice plan forcefully remind them? If not, you may be riding a free balloon that's bound for the stratosphere.

Prevention, on a broader scale, means setting up committees of doctors to look into all negligence complaints. Twenty-three such committees throughout Northern California have achieved striking success in

discouraging unwarranted claims.

Working closely with the insurance carrier, these committees check into some 225 claims a year. When they conclude that a claim has medical merit, the carrier pays off. When they find that a claim is unjustifiedas most are-the claimant gets nothing.

This speeds justice, protects good doctors, and jacks up the rest," one observer says. It's something to look for in any malpractice plan.

3. The Fighting of Suits

When you buy malpractice insurance, you want more than dollar protection. You want defense of your professional reputation as well. Yet some malpractice plans seem to specialize in "nuisance settlements," which seldom do the doctor's reputation any good.

In New Jersey not long ago, a woman patient with pains in her leg sued the physician who had given her spinal anesthesia. The insurance company settled for \$11,000 out of court. Local doctors, convinced that there was no malpractice, are wondering why they should help pay for this sort of thing.

Sometimes carriers are pressured into such settlements. Toward the end of a malpractice trial in New York, representatives of the defendant's three insurance carriers were

called into the judge's chambers. "Look," the judge told them, "there's no real malpractice here. But the patient is a 5-year-old child; her left leg is shorter than the other. Why don't you make a \$5,000 contribution to her?"

The insurance carriers agreed to contribute \$1.500 each, and the child was awarded \$4,500.

The evidence is accumulating that this is bad policy; that nuisance settlements breed more malpractice claims. Better look for some assurance that suits against you won't be settled without your consent.

An Iowa surgeon benefited from such an assurance. In 1941, he was sued for \$50,000 on a charge of negligence in the surgical treatment of varicose veins (the patient's leg had to be amputated). The insurance

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Niacinamide	

Folic Acid	1	mg.
Calcium (in CaHPO ₄)	250	mg.
Phosphorus (in CaHPO ₄)	190	mg.
Dicalcium Phosphate Anhydrous		
(CaHPO ₄)	869	mg.
Iron (in exsiccated FeSO ₄)	. 6	mg.
Ferrous Sulfate exsiccated (FeSO ₄)	20	mg.
Manganese (in MoSQ ₄)	0.12	mg.

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY POSIS River, New York



carrier fought the suit through eleven years of reversals and appeals, refusing every offer of settlement.

This defense cost the company \$3,500 in legal expenses. But it saved the surgeon's reputation. In 1952, after a six-day retrial, he was completely cleared.

Probably the best malpractice plans are those that inhibit both the insurer and the insured from settling too easily:

"Too often," says a malpractice committee in Tulsa, Okla., "the fear of newspaper and other publicity leads the accused doctor into panic, and he insists upon settlement of the case [regardless of] merit. Such action not only encourages further suits, but will eventually lead to a drastic increase in liability insurance premiums. However distasteful the publicity may be, the defendant-doctor must stand firm . . ."

So try to pick a malpractice plan whose carrier is resistance-minded and whose members are too. The Colorado plan has made this a rule: "No member . . . may compromise or settle any malpractice claim or suit without the consent in writing of the Medicolegal Committee . . ."

4. The Financial Limits

Recently a researcher from MEDICAL ECONOMICS interviewed doctors in several states to see how much malpractice insurance they were carrying. In New York City, he encountered the following men, one right after the other:

¶ A general practitioner with maximum coverage that would pay damages as high as \$200,000 per claim, \$600,000 per year. He'd just recently signed up for these high limits "because of what I've read about astronomical claims."

¶ An internist who carried no malpractice insurance whatever. "It's insurance money that attracts the vultures," he commented. "No insurance, no lawsuits!" ¶ An ophthalmologist—a member of his society's special malpractice committee—with \$5,000/\$15,000 limits. "I've been thinking of raising them," he said.

Which one of these three doctors has the best buy?

Well, the first man is pretty obviously overinsured. There's been only one malpractice award above \$50,000 in the history of the New York group plan—and he's covered for twelve such awards in one year!

The second man has an interesting idea. But having *no* insurance, he certainly can't be said to have the best buy.

Pretty clearly, the malpractice committee member knows what he's





These patients must conquer "diet fear"



Very few patients, particularly the obese, are able to diet successfully because they fear that the road they must travel to lose weight is an uphill struggle. Obocell eliminates "diet fear."



Obocell makes dieting easy because it curbs the appetite and suppresses "between-meal hunger." Nicel* and d-Amphetamine in Obocell work together to provide quick and sustained control of both hunger and appetite.



Obocell

doubles the power to resist food

Each Obocell tablet supplies:
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Phosphate
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Nicel* 150 mg.
*Irwin-Neisler's brand of specially prepared high viscosity methylcellulose.
Bottles of 100, 500, 1000.















in the dangerously overweight...

protect the liver too!

Grossly obese patients and those with a history of longstanding obesity invariably suffer from impairment of liver function.

Obocell Complex does more than help the patient lose weight...It supplies the needed protection for the liver, plus essential vitamins to support an overtaxed enzyme system in these special obese patients.

1. Zelman, S.: Arch. Int. Med. 90: 141, 1952.

I capsule with a full glass of water an hour before meals. If additional appetite suppressing effect is needed, increase the morning and noon does.

Section of fatty, fibrotic liver

Ontario

 Nicel*
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 Choline Startrate
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 Inositol
 50 me

 Thiamine Blochnitrate
 0.8 mg

 Riboflavin
 1.2 mg

"Irwin-Neisler's brand of specially prepared high

Bottles of 50 and 500.

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doing. He discounts the well-publicized claims against doctors. After all, anybody can make a claim, in any amount. Court awards or settlements are what count. Even in New York, these have risen above \$5,000 in less than 7 per cent of all cases closed over the last five years.

True, there's always that chance. Which is why this doctor is pondering whether to raise his limits—perhaps to \$25,000/\$75,000, perhaps even to \$50,000/\$150,000. But he still believes that "the lowest limits appropriate to your specialty and location" are every doctor's best buy. And nation-wide statistics seem to back him up.

How Juries Decide

As Dr. James Basil Hall's research revealed, a handful of malpractice cases have resulted in court awards up around \$100,000. But one was a case against the Federal Government; and in the others, the amount of insurance apparently helped determine the size of the awards.

"There is little doubt," says the general counsel of the Association of Casualty and Surety Companies, "that in a negligence case, the single circumstance that has the most influence on the jury is whether the defendant is insured."

Instead of concentrating on the question, "Was the defendant to blame?" this man adds, juries now ask themselves: "How much insurance was he carrying?"

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Plaintiffs' lawyers usually ask



Prompt pain relief in hemorrhoids.

greater safety from sensitization, toxicity

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practice. Supplied at all pharmacies. Cubott

1. Peal, L., and Karp, M., A New Surface Anesthetic Agent: Tronothane, Anesthesiology, 15:637, November, 1954.

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STERILE JELLY

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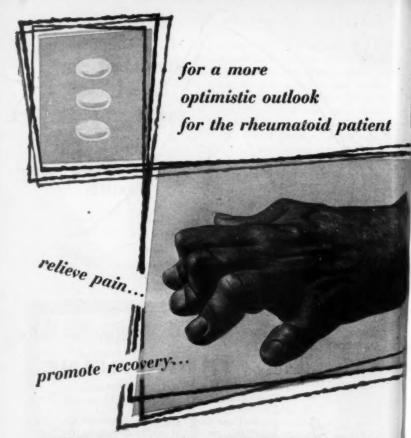
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themselves the same question. Take the case of a Midwestern surgeon who, suspecting malignancy, applied radium to a 74-year-old woman's mole. An infection developed, then a deep ulcerative condition exposing the bone. The woman required six months' hospitalization, plus surgery and skin grafting by another surgeon. When she'd recovered, she sued the first surgeon for \$25,000.

What defense did the surgeon have? Practically none. He claimed there was a confirming biopsy; the laboratory had no record of it. He claimed to have lost his own records on the case.

Just when things looked blackest for him, the plaintiff's lawyer discovered that the surgeon carried only \$5,000/\$15,000 malpractice insurance. Though the lawyer probably could have won the case in court, he accepted a \$3,500 settlement.

'King of Torts'

A spectacular example of the influence of insurance was reported recently in California. Melvin Belli, a trial lawyer widely publicized as



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the "king of torts," took the case of the plaintiff in a \$2½ million malpractice suit against a physician. That's right: \$2½ million!

Belli is the country's leading advocate of "more adequate awards." But when he found that the physician in this case had a \$5,000/\$15,000 malpractice policy, he was prevailed on to settle for \$3,750.

What Belli didn't know was that the physician also carried another policy providing ten times as much coverage. If he had known it, he presumably would have held out for \$37,500—ten times what he got.

One medicolegal authority re-

viewed 50,000 claims and suits against physicians with \$5,000/\$15,000 coverage throughout the Midwest. He could find fewer than fifty cases where the pay-off exceeded the policy limits. And in *no* case did the doctor have to pay an insupportable amount out of his own pocket.

Understandably, doctors in trouble spots like California, New York, and the District of Columbia may feel more comfortable with higher limits. Elsewhere your best buy may still be the lower limits. Overinsurance mercly scales up awards, settlements, and eventually premiums.

5. The Type of Contract

Malpractice policies have become rather standardized in recent years. But you'll still find some differences. And the differences may be important to you.

For example, what does the policy say about the settlement of claims against you? Be sure there's some such statement as this: "No claim covered by this policy shall be settled or compromised by the company except with the written consent of the insured." And be sure there's nothing else in the agreement that undermines this right.

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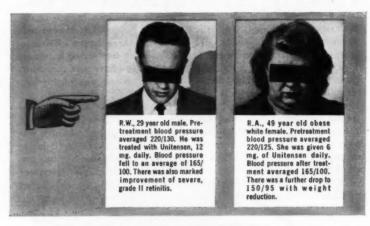
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What does the policy say about legal counsel? Some contracts specify that the company is to select the defense attorney; other contracts give the insured a voice. Still other contracts delegate the responsibility to the sponsoring medical society. Since defense can be worth more than dollars, be sure the attorney provided will suit you.

What does the policy say about appeals? Look for a clause as strong as this: "Defense will be maintained until final judgment in favor of the insured shall have been obtained, or until all remedies by appeal, writ of error, or other legal proceedings shall have been exhausted . . . "

What does the policy say about cancellation? There's no such thing as a noncancelable malpractice pol-

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icy. One individual contract specifies five days' notice; another specifies ten days' notice. Several group contracts call for six months' notice. In these days of skittish underwriters, you'll want to know where you stand.

And finally, what does the policy exclude? Some contracts exclude Xray therapy or spinal anesthesia; other contracts cover such things if you pay an extra premium. Similarly, you may not be covered for transfusions, cystoscopies, and surgical biopsies unless you specifically request it.

Naturally, you want the broadest coverage appropriate to your practice. There's no other way to be sure of it than to compare contracts, item by item. It's worth doing before you switch carriers.

6. The Type of Carrier

Four types of insurance company write malpractice policies today. Each type has certain distinguishing features that you ought to know about.

Most numerous are the big stock insurance companies—e.g., Aetna, New Amsterdam, U.S. Fidelity and Guaranty. About thirty of these companies belong to the National Bureau of Casualty Underwriters. They write coverage mostly on an individual basis and charge the same individual premiums within each state.

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Despite their fine record in other fields, some of these companies have been doing badly with their malpractice line. When Aetna began charging \$110 for minimum coverage in San Bernardino County,

Calif., that medical society's Bulletin commented as follows:

"This is an exceedingly unfortunate situation. The Aetna people advise us that they are helpless. They are in the business of providing malpractice insurance, but they must show a return to their stockholders...

"In addition to providing this insurance, they insist that each individual doctor also give them some additional supporting casualty insurance. This may be in the form of office liability, property damage, automobile insurance, etc. They state that they cannot stay in the field unless they are given this additional insurance."

Without tie-in sales, some big stock companies won't write malpractice insurance any more. Many an M.D. has complained about this:

"The physicians in West Virginia

^oThese premiums are listed in "What's Happening to Malpractice Rates," December, 1954, MEDICAL ECONOMICS.



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is now fully established as essential in human nutrition. This important member of the vitamin B complex is a major factor in the formation of red blood cells. It is, therefore, of particular value during infancy and pregnancy. When you prescribe a multivitamin preparation to meet these needs, choose one with a complete formulaone containing Folic Acid. For your convenience, most leading pharmaceutical manufacturers include it in their multivitamin products. This message is presented on their behalf.



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. . . resent being 'sandbagged' into purchasing any particular type of insurance," Dr. Russel Kessel, president of that state medical society, proclaimed last fall. But after reviewing the alternatives, Dr. Kessel soberly suggested that the "socalled package deal" might be the only "solution to our malpractice insurance ills."

Not all medical communities have reported such deals. U.S. Fidelity and Guaranty, for example, writes malpractice insurance for 90 per cent of New Jersey's 5,000 physicians. This volume (plus a close working relationship with the medical society) apparently provides steady enough profits to keep U.S.F. & G. stockholders appeared.

Stock companies that do lesser amounts of malpractice business in some areas may be forced increasingly to insist on tie-in sales.

Meet the Mutuals

More adaptable to the uncertainties of group malpractice plans are the mutual insurance companies. Employers Mutual underwrites the biggest group plan of all: the New York plan, with 15,000 members. It does it on a cost-plus basis, so that unexpected losses-instead of having to be absorbed-are passed on directly to the doctors in the form of higher rates.

A smaller and somewhat more successful group plan is underwritten by American Mutual. This is the plan covering 4,000 physicians in twenty-three California counties. Militant defense committees have made the plan click; but the carrier's cooperation has been notable.

Last year, for example, American Mutual felt the need of higher rates in California. But for five months it negotiated with medical society committees about the matter. According to Dr. James B. Graeser, one of the negotiators:

"Our committee checked every facet of American Mutual's experience, with the help of independent actuaries retained by the committee ... [These negotiations] resulted in premiums about 20 per cent lower than . . . those originally suggested by American Mutual." Rates for minimum coverage are now \$85modest, for California.

A mutual company's policyholders are, in effect, its only stockholders. Perhaps this permits greater flexibility in meeting the policyholders' needs.

They're Independent

Also attuned to the policyholders' needs are the small independent stock companies-those not affiliated with the National Bureau of Casualty Underwriters. One of these, St. Paul-Mercury, handled the group malpractice plan for the American College of Radiology. Though it dropped the group plan two years ago, the company still covers most radiologists on an individual basis.

St. Paul-Mercury also provides

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group malpractice insurance for most members of the Oklahoma medical society. Its rates there are standard stock-company rates. There's another St. Paul-Mercury group plan in Indiana; but fewer than 500 physicians have bought it.

Meanwhile, some 2,500 Indiana physicians have bought individual coverage from another small independent stock company: Medical Protective. So have 4.000 Texas physicians. So have three-quarters of all physicians in Illinois, Michigan, Minnesota, Wisconsin, Iowa, Kansas, Ohio, and Pennsylvania. Obviously this company has some special appeal. What is it?

Well, Medical Protective sells malpractice insurance only. It's been doing so for fifty-six years. Its legal department has defended doctors against 80,000 claims and suits. Its rates for \$5,000/\$15,000 coverage-the maximum it generally offers-are substantially below standard stock-company rates (e.g., \$25 vs. \$50 in Illinois).

Foreign Competition

Perhaps because they're small, these independent stock companies are pretty selective. Much more willing to accept bad risks are the big foreign insurance companiesnotably, Lloyd's of London.

Of course, they charge high prices for bad risks. Lloyd's has just about priced itself out of the market in California. And in New York to-



invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes... Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation. for 4 full bours... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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day, Lloyd's charges more than the medical society's group plan for such high-risk extras as electroshock and spinal anesthesia.

But the London combine has attracted many lower-risk M.D.s in New York by offering them malpractice insurance at roughly one-third less than the group plan charges. Whether these rates can be maintained, even Lloyd's representatives don't know. Without waiting to see, thousands of doctors are scrambling for London coverage.

Not being licensed in New York, Lloyd's can't actively solicit this business. But its Baltimore representatives can accept business that comes to them "without solicitation."

On this basis, Lloyd's has set up group malpractice plans for a number of New York hospital staffs and for the Kings County Physicians Guild. It also underwrites a group plan for the American College of Physicians. So far, about 15 per cent of all A.C.P. members have signed up. MORE



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a combination of 2 antibiotics
In one capsule provides

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From an editorial in the J.A.M.A. (156:991, Nov. 6, 1954):

Oral broad spectrum antibiotic therapy may cause infection with Candida albicans

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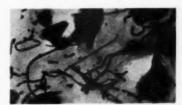
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Some clinical manifestations of moniliasis



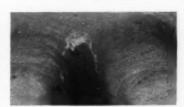
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Vaginal moniliasis



Thrush



Intertrigo



Systemic monilial infections involving the lungs, kidneys, bladder, brain, and heart have been reported. One group of investigators reported five fatal cases of moniliasis following antibiotic therapy. (J.A.M.A. 152:206, May 16, 1953).

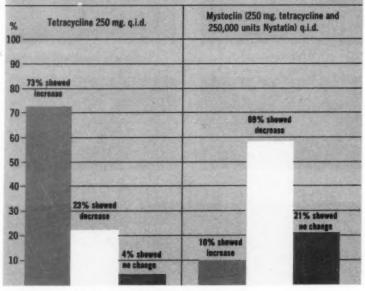
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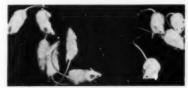
*Newcomer, V. D., Wright, E. T., and Sternberg, T. H.: Antibiotics Annual, 1954-55, Medical Encyclopedia Inc. In Press.

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better tolerated, more effective broad spectrum antibiotic therapy plus prophylaxis of intestinal moniliasis

Demonstration of protective effect of Mysteclin*



Candida albicans: all alive

48 hours after intraperitoneal administration of Candida albicans in 10 mice, all the mice were alive.



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Broad spectrum antibiotics increase the virulence of Candida albicans infections. 48 hours after intraperitoneal administration of Candida albicans and a broad spectrum antibiotic, all the mice were dead.



Candida albicans plus broad spectrum antibiotic plus Nystatin: all alive.

Nystatin has a protective effect against Candida albicans infections. 48 hours after intraperitoneal administration of Candida albicans, a broad spectrum antibiotic, and Nystatin, all mice were alive.

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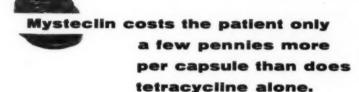
SQUIBB TETRACYCLINE-NYSTATIN

better tolerated, more effective broad spectrum antibiotic therapy plus prophylaxis of intestinal moniliasis

^{*}Newcomer, V. D., Wright E. T., Graham, J., and Sternberg, T. H.: Exhibit at Southern Medical Association meeting, St. Louis, Mo., November 8-11, 1954.

^{*}Brown, R., Hazen, E. L., and Mason, A.: Science 117:609, 1953.

^{*}Hazen, E. L., Brown, R., and Mason, A.: Antibiotics and Chemotherapy 3:1125, 1953.



Any patient sick enough to need broad spectrum antibiotics deserves the added protection against intestinal moniliasis afforded by Mysteclin.

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Is it unwise to deal with an unlicensed company like Lloyd's? Not necessarily. True, you have no recourse through your state's insurance department if you can't collect on a claim. But you may have recourse through the courts. The Lloyd's policy now specifies that the underwriters "will submit to the jurisdiction of any court . . . within the United States and will . . . abide by the final decision of such court or of any Appellate Court in the event of an appeal."

Are They Prepared?

The big question about foreign insurers is not, as a rule, their integrity. It's whether their experi-

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ence has prepared them properly for the American malpractice market.

If it has, a lot of American authorities will be surprised. But even their experience hasn't prepared them too well for what's been happening lately. So maybe the foreign competition will help broaden your buying opportunities.

Tips on Buying

Taking all these factors into account, then, how do you go about locating your best buy? Here are six suggested steps:

¶ Consider all the carriers that write malpractice policies in your state. Find out all you can—from

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The most discouraging feature of psoriasis is recurrence. Ormsby and Montgomery* write: "The disease often recurs, and may do so repeatedly for the greater part of a lifetime."

Clinical investigation shows that in psoriasis treated with RIASOL recurrence is exceptional. In a series of resistant psoriatics, classified as therapeutic failures to other drugs, there was improvement with RIASOL in 76% of cases, eradication of the lesions in 38%, and recurrence in only 19%. Such recurrences responded readily to further treatment with RIASOL.

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*Ormsby, O.S. & Montgomery, H., Dis-

eases of the Skin, 6th ed., 1943, p. 291.

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RIASOL FOR PSORIASIS

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agents, brokers, and colleagues about their losses, their rate increases, their financial reserves. Narrow your choice to the carriers with the best recent records.

¶ Favor the malpractice plan that gets you in with the best risks. In many areas, this means an individual plan. In others, it may be a group plan (not too large) that screens out bad risks or rates them up. Potential sponsors of such plans include your hospital staff, your medical society, your specialty society.

Protection Comes First

¶ Favor the plan that offers you the best protection—not the highest limits, not the lowest premiums. Protection means alerting doctors to the causes of claims, settling every warranted claim as quickly as possible, and fighting all unwarranted claims to the last court of appeal.

¶ Find out all you can about malpractice awards in your area. Establish your limits of coverage in the light of these awards, not in the light of preliminary claims. Set the limits at a level that will give you reasonable peace of mind.

¶ Review the contract carefully for its extra-risk coverage. Be sure you're insured for X-ray therapy and spinal anesthesia, if you perform these procedures; and be prepared to pay plenty—drawing whatever consolation you can from the fact that malpractice premiums are tax-deductible.

¶ If no one malpractice plan provides everything you want, consider taking out policies with two different carriers. It will cost 15 or 20 per cent more than a single policy. But it may be the only way you can get broad coverage, appropriate limits, and a fighting defense.

Wing Ding

• The revered Chief of Medicine was conducting our group of third-year medical students through the hospital ward on grand rounds.

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The C. M. smiled and pointed to a nervous student at his side. "Jackson," he said, "what is this condition of the nose called?"

Jackson hesitated, then blurted out: "Phimosis, Sir!"

—DONALD W. MOLINE, M.D.

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Blue Shield Faces Its Hour of Decision

Will it move forward from now on? Or backward? It can't stand still . . . Here are the specific challenges that confront it today

By James E. Bryan

• Twenty-five years ago, eight prominent American physicians, comprising the Minority of the Committee on the Costs of Medical Care, declared that "Voluntary health insurance schemes have everywhere failed."

"To recommend that our country again experiment with discredited methods of voluntary insurance," they warned, "is to ignore all that has been learned by costly experience."

Two major fears motivated these gentlemen; and it is only fair to say that they reflected the general sentiment of the profession at that time: First, they thought that voluntary health insurance would necessarily take the form of contract practice, through medical centers and group clinics. Second, they believed that any such voluntary plan would be pre-doomed to metamorphose into a compulsory scheme under Government control.

In the early Forties, the rising pressure for Federal medicine forced the profession to revaluate the voluntary

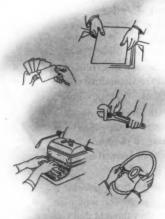
MR. BRYAN, a former executive secretary of the Westchester County (N.Y.), New York County, and New Jersey State medical societies and, more recently, administrator of the New Jersey Blue Shield plan, is now a consultant in medical administration and public relations.



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approach. At the same time, the patterns of organization and service that Blue Cross had developed suggested that a form of voluntary medical care insurance might be set up within medicine's traditional free choice, fee-for-service framework.

Hence, Blue Shield.

Today, after a decade of almost incredible progress, the Blue Shield movement faces a complex of problems so grave that unless they are realistically met, the gloomy apprehensions of a quarter century ago may yet prove justified.

In nearly every case abroad, voluntary medical care plans have been feeble forerunners of compulsory schemes. But the founders of Blue Shield were confident a decade ago that they could create a new and lasting brand of voluntary prepayment. They maintained that American medicine was imaginative and idealistic enough to evolve a program that the American people would buy.

And they were right. Never before in the history of actuarial science have so many people bought so many contracts in so little time.

ts.

Blue Shield blends human relations with economic science and the service philosophy of medicine. It has grown up in a period of spiraling inflation; and its success has stimulated hard-fisted competition by the commercial insurance industry.

Blue Shield is acutely sensitive at all times to changes in the general economy. It must roll with the punches. Above all else, it must strengthen its bond of understanding with physicians and the public.

Blue Shield has indeed sold the idea of health insurance to the American people. But the medical profession, through Blue Shield, still has to prove that it can and will provide, on a voluntary basis, a prepaid service that's as broad and complete as the people have learned to want.

A New Platform

If Blue Shield is to do the job it was created for, it must focus on at least seven specific aims:

 There must be a rebirth of the dedicated idealism that distinguished its pioneering days.

There must be a re-affirmation of service benefits as the cachet of Blue Shield operation.

 Blue Shield must achieve national stature and operate on a national scale, without sacrificing local community control.

4. It must preserve a balanced enrollment among the various classes of the population so it can cover the lowest economic groups at a community rate they can afford.

5. Blue Shield must win *organized medicine's support* nationally to the same degree that it has won doctor support locally.

6. It must identify itself with the individual physician—not as "just another insurance company" but as the doctor's own mechanism for providing service to everybody. [MORE ▶

7. Blue Shield must find ways to give the general public a more conscious sense of participation in the movement.

Rebirth of Idealism

The fact that less idealism and imagination are found in Blue Shield today is due to several factors. For example:

The very size of Blue Shield-the fact that it has become big business -naturally makes the average Blue Shield trustee more conservative now than he was when the plan began. New members of Blue Shield boards are, for the same reason, likely to be men of substance and caution, rather than of the gin-and-vinegar type that was needed to launch a new enterprise ten years ago.

An equally potent factor making for conservatism in Blue Shield is the slackening of political pressure for compulsory health insurance. Physicians are more complacent today. There has been a general relaxation-a return to "business as usual" -which may prove in the next few years to have been fatally premature.

Add to all this the normal effects of aging. Some of the boldest pioneers among the early physiciantrustees of Blue Shield plans have become the arch conservatives of today. These are the men who are constantly trying to call Blue Shield



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back to the narrower field of service for which, in their view, it was originally designed.

Some of these doctors are frankly alarmed by the expansion of Blue Shield. Like many parents, they can't bear to see their baby growing up. They long for the old days when they could pass on the salaries of the help and review most of the interesting cases in the course of a monthly board meeting.

Instead, they are now asked to digest ponderous actuarial analyses. They're required to place their trust in specialists and consultants in fields far beyond their ken.

Some of these erstwhile leaders suggest that Blue Shield "stabilize" its enrollment, that it eschew the drive for expansion, that it be satisfied with its present share of "the business." This, of course, indicates a certain weariness, plus a dangerous tendency toward retrospection. Worse still, it shows a total failure to understand the dynamics of Blue Shield. Such leadership can only be described as obsolescent.

Among medicine's rank-and-file, too, there's complacency. And this in the face of a challenge which seems to me more subtly threatening than any that loomed in the palmiest days of the Fair Deal!

As Editor Robert M. Cunningham of The Modern Hospital said recently, "Some doctors see Blue Shield as



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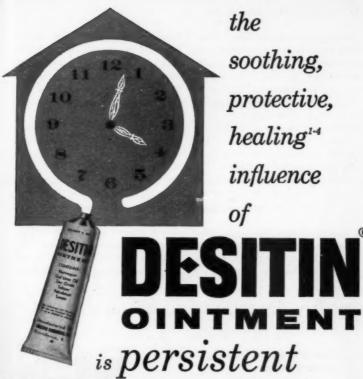
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 Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
 Turell, R.: New York St. J. M. 50:2282, 1950.

a means of improving their collections, rather than as a means of serving their patients. The moral deterioration that has been noted in politics and in business is having its effect on the honored professions. Unless its insidious attrition can be checked, no amount of scientific or economic wizardry can save the doctors and hospitals from a calamitous loss of public confidence. The patient expects them to think first of his needs, not theirs. When they do not, his disillusionment is disastrous."

Failure of Blue Shield and Blue Cross to help doctors understand the principles of insurance and to convince them that the plans do not have a pipeline to the U.S. Mint is reflected in profligate tendencies that have undoubtedly contributed to rising costs. Yet neither abuse nor overuse is doing as much harm, I feel, as the steps some plans are taking to control it.

Too many Blue Shield plans now are writing complicated restrictions into their contracts and loading them with legalistic gobbledygook. So they can scarcely blame some physicians for feeling that Blue Shield is "just another insurance company." In some instances, Blue Shield is doing its best to imitate the worst commercial insurance company practices—and this at a time when the commercial companies are

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*Barach, J. H.; Duncan, G. G.; Joslin, E. P., and Root, H. F.: Diabetes Mellitus, in Conn, H. F.: Current Therapy 1954, W. B. Saunders Company, Philadelphia, 1954, p. 368.

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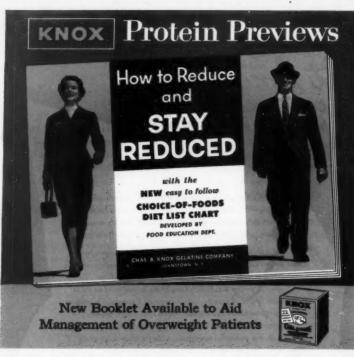
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taking heroic measures to reform those practices!

Blue Shield seems in danger of forgetting that its mission is to pay claims, not to decline them. It was designed to help patients, not to frustrate them. In a laudable but misguided effort to conserve funds, some Blue Shield directors are beginning to treat all doctors and subscribers like potential crooks—merely to trap the occasional sharpy.

A Poor Assumption

Dr. Francis T. Hodges, president of the California Physicians' Service, has criticized severely any contract "drawn on the assumption that there is going to be jacknavery on the part of the doctor or the patient." I've seen instances where plans have made extensive claim audits costing many times the value of the few overpayments that were eventually turned up.

I'm not saying that Blue Shield plans should not set up audit systems to safeguard their funds. What I do deplore is the effect on a plan's relations with its subscribers and physicians when caution is carried to the point of routinely mistrusting those whom the plan was organized to serve.

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Of course, some plans go to the opposite extreme: By hesitating to refer cases of exploitation of Blue Shield patients to the grievance committees of local medical societies, they miss a rare opportunity to contribute to better relations for the

profession and to rid the plans of a disciplinary function they have no business assuming.

Another major weakness of Blue Shield is the failure of the plans to come to grips with the issue of service benefits versus cash indemnities. Dr. L. Howard Schriver, immediate past president of the national association of Blue Shield plans, says "service benefits are a translation and implementation of the Hippocratic Oath and should be supported by every physician." Yet, even today, in at least twelve states, Blue Shield offers a cash indemnity program hardly distinguishable from that of a commercial carrier. In many other areas, income limits for service benefits are so low as to be a mockery of the service principle.

For example, there are seven plans, three of them state-wide, in which service benefits are limited to families with incomes not exceeding \$3,000. One other state has a family



income limit of \$3,200; one other plan, a \$3,500 limit.* There has been an almost universal lag in raising income levels of service benefit plans to keep pace with the general inflation of incomes and prices.

Unrealistic service benefits are worse than none at all. Accompanied usually by low fee schedules, they encourage physicians to levy extra charges on most subscribers whose incomes are above the anachronistic limits.

benefit of the doctor, then indemnity

If Blue Shield is organized for the

is the proper pattern. If it's intended mainly to serve the patient, then it should provide service benefits. "Only one contract will do for the people what they desire," Dr. Schriver says, "and that is a service contract. Blue Shield will never reach its potential as long as one segment writes a service contract and one segment writes indemnity."

The service benefit principle merits great credit, since it protects both the profession and the patient against the predatory physician who seeks to impose his own fee on top of the Blue Shield payment. The subscriber likes it because, under the service principle, he knows what he is paying for when he buys his

^eThe Department of Commerce reports, meanwhile, that in 1954 the average income of non-farm families was \$6,390, and that 41 per cent of all families had incomes of more than \$5,000 a year (an increase of almost one-third since 1947).

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policy. One of the main things the patient wants is assurance that he won't incur an additional charge when he has to avail himself of services covered by his contract.

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Yet today an overwhelming majority of American families who have any kind of medical care insurance are covered (if that's the word for it) by cash indemnity programs. Is this the protection they want? Are they going to be satisfied with it—for long?

"Service benefits are all that Blue Shield has to sell," says Dr. William H. Horton, executive director of Connecticut Medical Service. He calls them "the natural development of the ideals of the medical profession"-in fact, the only mechanism possible "in keeping with medical traditions."

Some thirty Blue Shield plans have maximum surgical payments of \$200 or less. Such substandard fees are defensible only if we accept Blue Shield as a charity program. Even then, they become an expensive charity for their intended beneficiaries because, as already noted, they encourage additional charges by the physician.

A schedule of inadequate fees makes it virtually impossible for an indemnity plan to convert to service benefits or for a service plan to raise its income limit. Such a schedule also puts a plan in an inferior com-



petitive position. It fails to satisfy the subscriber; it belittles Blue Shield in the eyes of most physicians; and eventually it cheapens medical services in the entire community. (If a Blue Shield plan thinks a tonsillectomy is worth only \$25, why should anyone pay more?)

Blue Shield's need to enroll national groups on a standard contract was discovered as far back as 1947. Yet despite many efforts to that end, and despite the existence today of the inter-plan organization known as Medical Indemnity of America, Blue Shield has not found the answer to this problem. Until most of the plans agree to offer one basic contract to multiple-state groups,

Blue Shield will not appeal successfully to those groups.

The more progressive service benefit plans cannot tolerate a national organization coming into their area with a competing indemnity program operating under the Blue Shield flag. The indemnity plans, by the same token, are fearful that their physicians would object to the local intrusion of a service benefit program. Yet as Benjamin Franklin remarked in an analogous situation, "We must all hang together, or assuredly we shall all hang separately."

The problem of developing a national Blue Shield package is closely related to the need of preserving a



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balanced enrollment in order to charge a "community rate."

Most of the accounts Blue Shield has lost or is in danger of losing to its commercial competitors are "blue-chip" accounts. These represent employes of large corporations, who enjoy relatively high earnings. Not only do their employers pay them well and give them the benefit of in-plant industrial medicine and hygiene, but many of these employers also pay all or part of their workers' health insurance premiums—thus assuring a fair selection of risks within the group.

The claim costs of such "bluechip" groups are naturally less than those of other groups in which wage levels are lower, sickness and accidents are more frequent, the employe pays the premium, and the healthier risks often choose to stay out rather than pay for coverage they may not need.

I've referred to the "community rate" as a principle peculiar to voluntary health insurance. But what is a "community rate" and why is it so vital?

Blue Cross and Blue Shield were established to serve the entire community, but most especially to serve people of low income—those who are least able to pay for medical care and who need it most often. Probably no one will dispute the idea that unless voluntary insurance takes care of the low-income groups, government will have to do so. But the fact is that our voluntary program

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has failed so far to cover these groups to an extent comparable with its coverage of the middle- and higher-income strata.

A recent survey conducted for the Health Information Foundation showed that while 80 per cent of families with incomes over \$5,000 a year carry some kind of health insurance, only 70 per cent of the \$3,000-\$5,000 income group and only 40 per cent of the under-\$3,000 group have such health protection. The median income of insured families was found to be about \$4,500; of uninsured families, \$2,700.

Enrolling Individuals

A big job must be done also to enroll those who are not members of employe groups. The Health Information Foundation learned that only about 20 per cent of the people who have any kind of voluntary health insurance enrolled individually. It also found that while 70 per cent of urban families have some health insurance protection, only about 45 per cent of rural-farm families have it.

Blue Cross and Blue Shield established a single premium rate for the entire community so that they might give the same service at the same price to all persons. This was designed to enable even the lowest-income groups to take part. Since there are normally only one Blue Cross and one Blue Shield plan in a given community, the plans can aim for such community-wide enroll-

ment at a community-wide rateexcept when commercial insurance competition hampers the attempt.

Parenthetically, when one grasps the meaning—and the vital importance—of the community concept, it at once becomes clear why Blue Cross and Blue Shield are not "just another insurance company." They are not insurance companies at all, but community prepayment plans.

While the commercial insurance industry may proclaim the goal of community service, the individual companies cannot possibly function like nonprofit community plans. As Dr. Carl M. Fischer, professor of insurance at the University of Michigan, has pointed out, "Each company endeavors to secure as favorable a portion of the community as practicable so that it can furnish the protection to its own policy-holders at the lowest possible price and/or make the greatest profits for its stockholders. Thus the individual companies are apt to compete for the cream of the business and neglect an important segment of the community." (Italics are mine.)

A community rate is based on the assumption that the community as a whole (usually an entire state) is the group whose experience should determine the cost of prepaid medical care. The insurance companies, however, have pointed out to employers of the "blue-chip" groups that in Blue Cross and Blue Shield they are paying more than the experience of their own group alone

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When the low-cost groups are plucked out of the community pool this way, the per capita cost of giving the same service to the remaining groups inevitably goes up. And as the cost rises, more and more of the lowest-income people—who need coverage most—drop out of the plans.

Here, obviously, are the makings of a vicious cycle. Unless the cycle is broken, the plans will fail in their effort to provide a community-wide service. Those who need protection most will have nowhere to turn but to government.

How can we break this cycle?

National Leadership

The future of Blue Shield-indeed, the future of America's free system of medical practice-depends on the willingness of the American Medical Association to recognize Blue Shield as the profession's own creation.

Medicine is not in the insurance business; but it is in the business of providing medical service. Blue Shield was conceived by the profession to make such service—not cash—available.

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Preventive medicine is critical to the infant, because his underdeveloped capacity for maintaining homeostasis renders him acutely vulnerable to the stresses resulting from inadequate management. For the normal infant, good nutrition is an essential consideration. It is of particular concern to the physician, and supervising it maintains the contact with the patient necessary for continued preventive care.

i i v p b

We hold inviolate the prerogative of the physician to prescribe infant feeding according to his judgment. The physician has the training and experience necessary to select and prescribe the formula and other elements of the dietary, and to direct the preventive care of the infant. The contribution offered by the paramedical professions can be best utilized under his supervision. We believe it incumbent on M & R Laboratories to encourage and to participate in research in the field of nutrition, both fundamental and applied. The M & R Pediatric Research Conference program is but one instrument for achieving this objective.

Promotion of an infant feeding should be confined to demonstrating the merits of the feeding to the medical profession, and to providing the information necessary for proper use of the feeding to the allied professions.

Our representative to the physician is chosen for his integrity, is trained in the knowledge of his product and its application, and is schooled to respect the physician's position and conduct himself with propriety. His function is to develop product understanding, and to render services to physicians that will facilitate application of the product in their practice, without any attempt to incur obligation for such services.

Similae advertising is directed only to physicians and those professionally associated with them, and is concerned with the presentation of data from the scientific literature substantiating the principles underlying the formulation of the product.

M & R Laboratories believes that no action should be taken by commercial interests to produce pressures from lay sources designed to influence the physician's prescription of any product or type of product.

Efforts to create brand preference or to publicize medical concepts for commercial gain, through the use of mass media such as television, radio, newspapers and magazines, can only result in undesirable pressure on the physician from patients. Lay promulgation of brands of infant formulas or foods intended for the first year of life infringes on the right of the physician to prescribe as his judgment directs.

We believe that the public welfare and the prestige and effectiveness of medicine depend on the continued recognition of the prerogatives and responsibilities of the physician. Relegation of these responsibilities to other interests can only lead to a deterioration of medical care and a threat to national standards of health.

While M & R Laboratories transacts its affairs to make a profit for the company, we feel that this is most appropriately done by providing what we believe to be the best possible product, at the lowest possible cost, marketed under this code of business principles.

Dave Cox, Director



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M & R LABORATORIES . COLUMBUS 16, OHIO

Medicine's national association owes it to itself to give the same guidance and support to Blue Shield that most of its state and local societies give the plans within their jurisdictions.

Only when such national leadership is a fact will Blue Shield attain the stature it needs to enroll and service national accounts. Only then will Blue Shield resolve the issue of service versus indemnity. Only then will it be able to resume progress toward a balanced enrollment of the American community.

Blue Shield can break the cycle that is compromising the community concept by improving its product and by merchandising the unique features of that product (viz., service benefits; professional approval; local control; community service; and low-cost, nonprofit operation).

It must "sell" the leaders of industry and labor on the long-range necessity of their (1) supporting community-wide enrollment at the community rate and (2) spurring the low-cost, "blue-chip" groups to share the cost of making health services available to the high-cost, low-income groups. The point must be brought home to these leaders that the fate of free enterprise itself may depend on our solving the community medical care problem by voluntary means.

There is, by the way, as great a

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more potent than cortisone or hydrocortisone devoid of major undesirable side effects

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fatty, damaged liver is common in obese patients

the original complete lipotropic therapy

methischol helps mobilize fats from the liver, reduce fatty deposits and fibrosis, stimulate regeneration of new liver cells, generally improve liver function.

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atherosclerosis, and coronary disease with abnormally high cholesterol and lipid serum levels, are frequently observed in the overweight, methischol improves fat and cholesterol metabolism and often reduces pathologic levels towards the normal.

choline • methionine inositol • vitamin B₁₂ • liver

Capsules: bottles of 100, 250, 500 and 1000.

Syrup: bottles of 16 oz. and gallon.

impaired carbohydrate tolerance, due to liver damage, is prevalent among obese persons. methischol helps stabilize blood sugar levels by acting to restore normal liver function.

*Methischol is a valuable complement to drug therapy, diet, exercise, vitamin-mineral supplements (such as Vi-Aquamin Therapeutic), psychotherapy, etc.

danger in the doctor's becoming too exclusive a proprietor of Blue Shield as in his ignoring it altogether. We encounter too often the physician who says, in effect, "This is my plan, and I will run it to suit myself." Let him remember that it's the subscriber who pays the bills; and the subscriber is interested in Blue Shield not as "the doctor's plan" but as the patient's plan, created and serviced by doctors.

The public relations problem of the Blue Shield is essentially one of identification. Blue Shield is approved by organized medicine, of course; yet few private physicians seem to appreciate that their fate is bound up inextricably with that of Blue Shield. They do not yet realize that if the Blue Shield idea fails, the voluntary health insurance movement is through. They'd better get acquainted with Blue Shield and

support it if they expect it to carry out their community responsibility.

Either Blue Shield—with all its accomplishments, its shortcomings, and its potentialities—is the expression of the American medical profession, or it is not. If it is, then let's have the national leadership Blue Shield so urgently needs. If it is not, then medicine had better get itself another program—and soon!

Blue Shield must gain a clear identification with the American community. People have confidence in the plan because they have confidence in America's doctors. The profession can't afford to forfeit that trust.

Blue Shield carries the burden of destiny not only for private medical practice but possibly for our free society itself. It merits the best that American medicine can give it—in vision and in leadership.

Just Considerate

• At 1 a.m. a colleague of mine was rung out of bed for an emergency call ten miles out of town.

The patient proved to be a sort of Milquetoast with nothing more wrong with him than a simple cold. He said he'd had the cold, moreover, for three days.

"Why the devil, then, did you call me out here in the middle of night?" my friend asked testily.

"Well, Doctor," he sighed, "I knew I couldn't pay you. And—well—I just didn't want to bother you during the day when you're busy with your paying patients!"

-GEORGE H. MASSEY, M.D.

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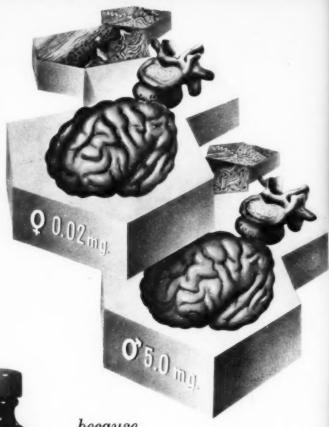


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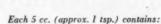
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Pamine*-Phenobarbital Elixir



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Dosage:

1 to 2 teaspoonfuls three or four times daily, depending upon requirements in the individual patient.

Supplied: Pint bottles.

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The Abortion Racket

By Edwin M. Schur

FEW LAWS are interpreted so narrowly as those on abortions. So many a physician who sees the need for a therapeutic abortion thinks twice about recommending it.

The specific problems such a doctor faces were taken up in a recent article in MEDICAL ECONOMICS ("Fine Points of the Law on Abortions," December, 1954). The following article, condensed from The Nation (March 5, 1955, issue), goes a step further: It asks whether the present laws should remain on the books.

The author's answer—a resounding "NO"—may not be your answer. But you'll find his article a thought-provoking one. It's based on a prize-winning study of the abortion problem that he undertook as a student at Yale Law School.

 Despite abortion's skyrocketing death rate, talk about it is hushed up, and the law remains powerless to curtail the activities of the professional abortionist.

Gynecologist Frederick Taussig in his 1935 study estimated that there were 681,000 abortions annually in the United States, of which about 60 per cent were illegal. A few years ago the chief medical examiner of Maryland, making what he considered a conservative estimate, held that there were 1 million a year, of which 30 per cent were illegal. Other recent studies of the abortion situation assess the number at between 300,000 and 400,000 a year.

(1/s gr.)

depend-

gan

Laws against abortion are supposed to curb immorality among the young; but statistics show that the majority of abortion-seeking women are married and that many are already mothers. Another mistaken idea is that few Roman Catholic women seek abortion; actually women of all religions resort to it.

Estimates of the number who die every year as a result of abortions and abortion attempts range from 3,000 to

THE ABORTION RACKET

8,000. If death does not occur, there is a strong possibility of partial or complete sterility, endocrine disorders, menstrual disturbances, or psychic maladjustment.

These shocking results need be expected, of course, only when the operation is performed covertly by unskilled persons, without modern scientific equipment. But with the legal situation what it is, most abortions inevitably are attempted under these conditions.

Foolish Laws

The law has shut its eyes to these facts. Fifteen years ago B.B. Tolnai wrote in The Nation that "the foolishness of abortion laws in this country amounts to a tradition." The tradition still flourishes.

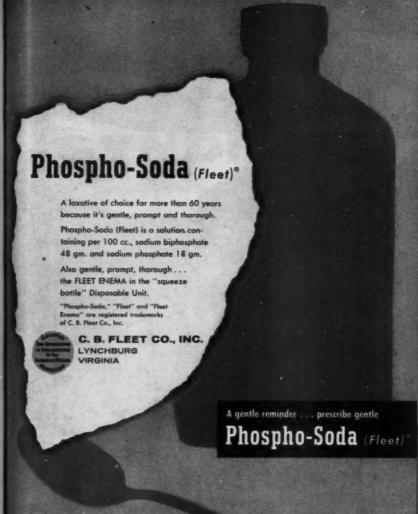
Tolnai went on to say that "the result of existing legislation is an anarchy of extra-legal practice, opening up bonanzas of graft to crooked lawyers, politicians, and doctors." The anarchy and the bonanzas persist.

The present legal status of abortion in this country can be summed up in one sentence: Abortion is illegal unless necessary to preserve the life of the mother. Not all states have such laws, but the majority do.

"Necessity" as the sine qua non of a legal abortion puts the doctor in a perilous position. He cannot know for certain that without an op-



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eration the woman will die. Even if consultation with other physicians confirms his decision, he may not be able to support it in court.

Prosecutions Are Few

The rigidity of American law is pointed up by the decision of an English court in the well-known case of Rex versus Bourne (1939). A fifteen-year-old girl became pregnant as a result of forcible rape. Bourne, an eminent physician, performed the operation openly in a London hospital, asking no fee.

Charged with "unlawfully" procuring an abortion, he was acquitted. The judge stated that when the doctor on reasonable grounds believes the pregnancy will make the woman "a physical or mental wreck," he is entitled to perform the abortion.

In most American states neither rape nor incest constitutes justification for abortion; and no humanitarian, social, or economic factor is taken into consideration.

This rigidity, coupled with the persistent demand for abortion, has led to a scoffing disregard of the law. Prosecutions are few, and the conviction rate is extremely low. Of abortionists who are convicted, a great many receive suspended sentences.

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Taking away a doctor's license, as is done in many states, is an ineffective sanction: An abortionist needs no credentials to attract clients.

In big cities an abortion practice

is highly lucrative; often it is elaborately organized. District Attorney Frank Hogan of New York, in his report for 1946-48, noted an "enterprise" conducted by two women, neither licensed to practice, who used a "palatial private residence on Fifth Avenue" as a front:

'Special Delivery'

The conspirators [said the report] had a complicated code system for telephone conversations. Payments were "packages." "Six pairs of nylons" or "eight pairs of nylons" meant that the patient was six to eight weeks pregnant. Information concerning a patient's financial status was imparted by terms such as "special delivery," which indicated ability to pay double the usual fee, or "parcel post," meaning a moderate increase over the usual charge.

The professional abortionist can



THE ABORTION RACKET

be demanding without fear of disclosure and may force his patients to beg, borrow, and steal in order to pay him. One hears of cases in which the "doctor" even indulges his sexual whims, threatening not to perform the abortion if he is resisted.

Hypercautious, the abortionist keeps his equipment at a minimum and as portable as possible. He works through "contacts"; and his records, if they exist at all, are in code or scrupulously hidden.

It must be recognized, however, that he provides the only facilities for meeting a social need. He exists because the public lets him. Public opinion for the most part is not against the practice of abortion.

Fewer and fewer therapeutic abortions are currently being authorized. For one thing, many conditions which used to be detrimental to the continuance of a pregnancy are now handled without danger. For another, uncertainty fostered by the law has led hospitals and individual doctors to avoid going out on a limb. The increase in abortions for psychiatric reasons has not offset the decline in those for physiological reasons.

Since there is no reason to assume a decline in the demand for abortions, the reluctance of hospitals and

reputable doctors to perform them can only lead to an increase in clandestine operations and a consequent reservine A tranquilizing, antihypertensive, alkalaidal principle of Rauwolfia WORKING serpentina. rotoveratrines) A and B Complementary SYMPTOMATIC TREATMENT hypotensive Veratrum OF MODERATE AND alkaloids. EVERE HYPERTENSION a joined therapy

rise in mortality. It would be realistic to loosen rather than tighten restrictions.

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clanquent Under Swedish law today, abortions are permitted on eugenic, social, and humanitarian grounds, as well as on purely medical grounds. This statute, together with an active information program, has caused a large drop in abortion deaths and the continuation of many pregnancies that women had planned to interrupt.

In the United States, the strong moral feeling against abortions helps keep ineffectual laws on the statutes. It is asserted that killing the fetus contradicts the basic sexual function of women, that in destroying the unborn child, woman denies her own "maternal instinct."

The psychological after-effects suffered by many aborted women has been cited in support of this argument. Yet it can be argued that the guilt reaction is due largely to society's opposition. Can we not say in all truthfulness that the fact that abortion is "illegal" may be the major cause of these reactions?

'Useless Scruples'

Probably a woman's views are seldom so advanced that she is completely immune to society's condemnation. Simone de Beauvoir puts it very well, I think, when she refers to torment "by useless scruples."

MORE

potensive drugs with complementary tion: Reserpine simultaneously lowers blood pressure, slows the heart rate d provides sedation of an exceptional ality, unlike that of barbiturates in at it does not induce sleep. Protoveraces A and B produce a more potent potensive action, with significant decase in the systolic and diastolic presses of most patients. Together, these refully chosen alkaloids provide the valcian with a flexible, effective agent management of moderate and severe pertension.

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INDICATIONS: Moderate and severe essential hypertension. Symptoms resulting from hypertension such as headache, insomnia, dizziness, blurred vision and nervousness may be alleviated.

ADMINISTRATION Suggested starting dosage schedule: 3 tablets daily, 1 after each meal at intervals of not less than 4 hours. In intractable hypertension, increase dose by one-half tablet daily at intervals of four to seven days. If nausea, vomiting or other side effects appear, dose should be reduced by one-half tablet or as necessary to obtain desired effect short of overdosage.

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... would be required to equal the 25 mg. thiamine content of a single capsule of "BEMINAL" FORTE with VITAMIN C, which also contains therapeutic amounts of other essential B factors and ascorbic acid as follows:

Thiamine mononitrate (B₁) 25.0 mg.

equivalent to move than 400 eggs

Riboflavin (B₂) 12.5 mg.

equivalent to at least 8 slices of liver

equivalent to more than 10 loaves of bread

Pyridoxine HCl (Be) 1.0 mg.

equivalent to about 14 servings of spinach

Calc. pantothenate 10.0 mg.

equivalent to almost 4 quarts of milk

Vitamin C (ascorbic acid)100.0 mg.

equivalent to more than 15 apples











"BEMINAL" FORTE with VITAMIN C



Recommended whenever high B and C levels are required and particularly pre- and postoperatively. Suggested dosage: 1 to 3 capsules daily, or more as required.

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The "instinct" premise is reinforced by the traditional view of woman's role in our society. Most abortion laws are man-made, and women have not been given many opportunities to express themselves on the subject.

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Women Voted 'Yes'

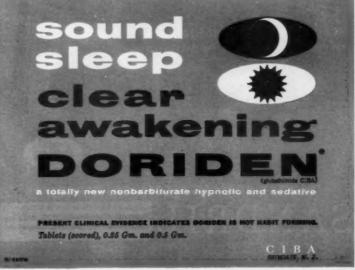
Taussig cites two questionnaires sent out in the 1930s—one to members of a Danish women's organization, the other to graduate women physicians in Germany. In each group a majority believed abortions should be permitted when socioeconomic factors made them advisable. A similar result might be expected in a poll of American women

today if the veil of shyness on the subject were pierced.

The feminist goal will never be reached until woman has achieved social sanction for the right to decide when she shall have children. With abortion laws as they are today, the American woman is not free to make this decision. The high demand for abortion shows that women want freedom in this regard.

A highly irrational system of sex ethics gives further support to our present abortion policy. Ours is certainly a sex-conscious society. All our mass media play up sex. It is the inarticulate basis of almost all our advertising. Even comic books exploit sex in its rawest aspects.

MORE



THE ABORTION RACKET

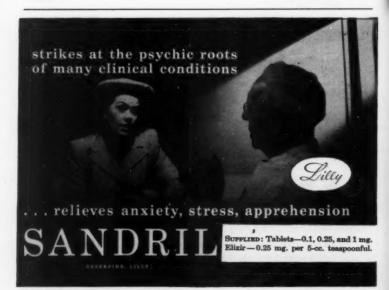
But our social conventions insist that sex is wrong. A good example is the motion-picture industry's production code. Another is the widespread custom of calling jokes about sex "dirty" jokes.

Though in practice the "double standard" is losing its power, it still affects our thinking. For example, 44 per cent of the women interviewed by Kinsey listed "fear of public opinion" as a factor that had restricted their pre-marital sex relations; 89 per cent said that "moral considerations" had been of primary importance. Abortion, representing sex without procreation and often sex without marriage, still carries a harsh stigma.

The Roman Catholic church has led the fight against abortion reform. Refusing to distinguish between various forms or stages of life, the church claims abortion is immoral because it violates the Commandment "Thou Shalt Not Kill" and is in conflict with the doctrine that when death occurs without baptism the soul is damned. Under canon law abortion is grounds for excommunication, no matter what the reason may have been.

Voice of the Church

The voice of the church is greatly strengthened by the unprotesting attitude of the general public. Lawyers blame doctors for causing the



Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

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- food intolerances
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- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipction: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastire pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces,

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Meyenberg Goat Milk is free of crude fibers associated with other cow's milk substitutes - as a result Meyenberg Goat Milk cannot cause diarrhea.

Delicate systems can more readily digest Meyenberg Goat Milk.

Specify Mayenberg Goat Milk first.

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abortion problem. Doctors in turn blame lawyers. But the real impediment to progress is public indifference. The average citizen certainly spends little time thinking what should be done about abortions, although it's highly possible that his own wife or sister or daughter may some day need one.

Change Can Be Forced

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Public opinion, once aroused, could force a change. Legislators cannot ignore a categorical demand of the voters.

Completely legalized abortion would probably be the best solution;

the sooner we abolish the idea that abortion is a "crime" the better. But even to establish social-economic or psychological conditions as legal grounds for abortion would be a tremendous step forward.

While the use of a simple, fully dependable contraceptive could to a great extent solve the abortion problem, it may be a long time before such a method, even if permitted by law, becomes generally available. Meanwhile unlawful abortion continues to flourish, with all its ill effects on the female population. Its continued cost in death and injury must not be tolerated.





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ONE CAPSULE DAILY

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Intrinsic Factor-	Vitamin B ₁₂	
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Molybdenum	1	.5 mg.
Cobalt	0.	5 mg.
Copper	0.	5 mg.
Manganese	0.	5 mg.
Zinc	0.	.5 mg.

Bottles of 30 and 100 Prescription only Only one-a-day hematinic which conforms to exact U.S.P. requirements for Intrinsic Factor-B₁₂, as defined by the Anti-Anemia Preparations Advisory Board.

Only one-a-day hematinic which contains therapeutic amounts of all known hemapoietic factors, including the "four extra essentials."

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CHICAGO 11, ILLINOIS

I Dispense—and I'm Proud of It!'

A doctor damns druggists who (at the patient's expense) want to abolish physician-dispensing

By Jonathan M. Clark, M.D.

 I'll admit it. I'm sore. I'm sore because druggists are trying publicly to pillory any physician like myself who dispenses.

They're shouting "unfair competition," "violation of free choice," and "unethical practice"—all good, sound terms that they've neatly distorted. They've even raised a fat fund to plaster one state (Wisconsin) with newspaper ads describing us as selfish ogres [see "Druggists Draw Bead on Dispensing M.D.s," MEDICAL ECONOMICS, February, 1955]. Never once do they mention who really gains from doctor-dispensing and who would suffer if it were stopped: the patient himself!

Let's look at it from the patient's view. Here's what he gets when a physician does the dispensing:

 \P Exactly the medication his doctor wants him to have. No substitutions.

¶ His prescription filled when the patient needs it. He doesn't have to make a special trip to the drugstore and wait till his medication is ready. What's more, if all the drugstores are closed, he avoids a delay of several hours

THE AUTHOR, who for obvious reasons uses a pseudonym, is a G.P. in a small town in the South. While his views aren't necessarily those of the editors, MEDICAL ECONOMICS feels they deserve a hearing.

'I DISPENSE-

or even a day. Remember, he's a sick man; otherwise he wouldn't be needing medication. So it's his time and energy that must be considered.

¶ Finally, he may save a little money on the prescription. Is that

bad? Just ask the patient.

Seems to me the only thing we dispensers deprive him of is the questionable pleasure of roaming through a so-called drugstore and being waylaid by offers of electric toasters, bubble gum, and Handi-Pandi-Pots, when all he really wants is to get his medicine quickly and get home to take it.

Competition Pricks

Sure, we may be competing—in a very small way—with the druggist. But look who's talking about competition! The "pharmacy" competes like mad with every other store in town: the hardware store, the book shop, the stationery store, the restaurant, the delicatessen, the ice cream parlor, the electric appliance store—even the grocery.

How long since you've seen a drugstore that sells only pharmaceuticals? I've merely read about them; they're that much of an oddity. Looks as if the druggist objects to competition only when it hits him.

They say our dispensing is "unethical"—that we violate the A.M.A. code. Do we?

The Principles of Medical Ethics state that in no event may the doctor's financial interest in dispensing

Rx INFORMATION Nitranito a dreet excelliation plus the aided central hypotensive and aiming actions of Rauwellia expenting Nitranitol R.S. Mannitol hexanitrate . 32 mg. Rauwollia serpentina (alserczylon fraction) . 0.5 mg. Nitranitol e eals, gradual, prolonged Vicanital hemonitrate . 32 mg. Nitranitol with Phenobarbital for the nervous hyperlessive Monnitol hexanitrate . 32 mg. Phenobarbital 16 mg. Nitranital with Phenobarbital and Rutin* for protection in contlicity transility with Rutin 20 mg. Nitranitol with Phenobarbital and Theophylline* in threatened ourdies influre with Theophylline . . 100 mg. Nitranitol P.V.* DOSAGE: In blood pressures over 200 systolic, 2 tablets four times daily. In other cases, I or 2 tablets every four to six hours. Bottles of 100 and 1,000. NOTE: Nitranitol is exceptionally stable, assuring uniform potency, so important in medication for your hypertensives. Each contains mannitol hexanitrate 32 mg. and phenobarbital 16 mg.

THE WM. S. MERRELL COMPANY New York - CHICARATI - S. Thomas, Canada in hypertension

Nitranitol Rauwolfia

. tandem action for safe, gradual, prolonged relief



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distressing symptoms... slower acting Rauwolfia for prolonged hypotensive and quieting action -- no lag in symptom relief. The combination means normal life sooner for your essential hypertensives ... no jolting of the vasomotor reflexes ... side effects are uncommon.

RAUWOLFIA write: Nitranitol

for a more normal life sooner for your hypertensive patient



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NEW_for weight gain high-calorie food supplement

MorCal*

with B. and B.

won't be just "tolerated" by your underweights...they'll love it!

adds variety, doesn't satiate

MorCal provides a new, pleasant way to add taste-tempting variety to the weight-gain diet. It's delicious "as is," or topped with fruit and milk for breakfast or between-meal snacks. Cereal-like MorCal can be added to or mixed with almost any food on your patients' menus. This new fat preparation doesn't satiate, leaves no cloving aftertaste.

easy to use in cooking or baking

MORCAL can be used as a substitute for most of the flour in cooking and baking, often increasing calorie content 30 to 100 per cent. It adds flavor as well as calories to desserts, soups, gravies, sauces, etc.

prescribe MorCal

for overactive, fast-growing youngsters, underweight adults, convalescents, the chronically ill, and elderly patients. Just two rounded tablespoonfuls four times daily (120 grams) add 720 extra calories to the diet—plus $12\frac{1}{2}$ times the minimum daily requirement of vitamin B_1 and $6\frac{1}{2}$ times the suggested daily supplement of vitamin B_{12} .



shows your patients many taste-tempting ways to add calories and variety to their weight-gain diet. Prepared by our home economics consultant, this "Recipes and Uses" booklet is enclosed above the inner seal of each one-pound tin of MorCal. A supply of these recipe booklets is yours for the asking—just let us know how many you require to give to your patients.

Morcal contains refined vegetable fat 44%, carbohydrate 42%, protein 9%, mineral ash 2.5%, moisture 2.5%, vitamin B₁ (thiamine mononitrate) 50 mg. per lb., and vitamin B₁₂ (cyanocobalamine) 50 mg. per lb. Morcal is prepared from hydrogenated cottonseed oil, proteins and carbohydrates from dried skim milk solids and wheat flour, natural flavorings, synthetic vitamins B₁ and B₁₂.

MORCAL IS SCHENLEY LABORATORIES TRADEMARK FOR A HIGH-CALORIE FOOD SUPPLEMENT.
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TAMPAX eliminates these common menstrual discomforts

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PERINEAL IRRITATION...
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Accepted for advertising in Publications of the American Medical Association

TAMPAX INCORPORATED PALMER, MASSACHUSETTS

be "placed above the quality of medical care." I don't know of a single doctor who would sacrifice his patient's welfare for any amount of money.

I'm willing to dispense drugs without taking a profit (though my costs are pretty hard to figure); and I'm sure most other doctors are, too. Would the druggists do the same for the sake of the patient?

No, I suspect the druggist is playing possum when he complains about doctors making a "profit" in drugs. What really irks him is that the doctors don't make a profit and the patient saves money.

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ing the ion ED Instead of limiting the patient's "free choice," we dispensers are ac-

tually giving him another choice and a better one. If he'd rather go to a drugstore, he's free to do so. There's not a doctor anywhere who would *insist* that a patient get his drugs from him.

I'm always careful to tell the patient that he can have his prescription filled at any drugstore, though I'll do it for him, if he likes, as an accommodation. Secretly—while dispensing is a bother to me—I often hope that the patient will ask me to do it. For then I can be sure no substitutes will be foisted on him.

Like most of us, I have some "pet" pharmaceutical specialties. Several years ago I prescribed one of them for a patient on three sep-



"According to this chart I should be six inches taller!"

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without the undesirable effects associated with the usual opiates or their derivatives commonly employed in cough control.

Toclase Syrup

Bottles of one pint

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Bottles of one pint

Toclase Tablets

25 mg., bottles of 25



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arate occasions. Shortly after I'd given him his third Rx, he came to my office and plunked three bottles down on my desk. One was what I had prescribed; the other two were substitutes. They were what his drugstore had supplied as "filling" the prescription. "How is it," my patient asked, "I got three different medicines with the identical prescription?"

That Did It

I had no satisfactory answer for him then. I do now. That incident was what started me off dispensing my own drugs.

I'll grant that some substitutes druggists sell are fair copies of the original. But I can't be sure. I can be sure there are no substitutions when I fill prescriptions myself.

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RIES Co., Inc. In my town, there's a lot of counter-prescribing too. There's hardly a pharmacy that won't "suggest" some drug to a customer, especially if the pharmacy compounds medications of its own, as some do. So I can't protect a patient unless he

comes to me for medication as well as treatment.

Of course, I won't be able to do this in the future if the druggists succeed in their campaign to abolish all doctor-dispensing. Too bad our hands are tied in trying to stop them. We'd consider it highly unethical if we were to go to the public and plead our cause in flamboyant newspaper ads, as the drug men are doing in Wisconsin. And they're not doing it with peanuts, either; they're spending \$25,000 as a starter.

Up to the Patient

I'm counting on the good sense of the average patient to tell him what's really best for him. He must realize that a doctor, with long years of training and experience behind him, is the one who's best qualified to fill a prescription as well as write one (and without the profit motive, so there's no doubt that the patient's welfare comes first!).

That's why I dispense. And I'm proud I do.

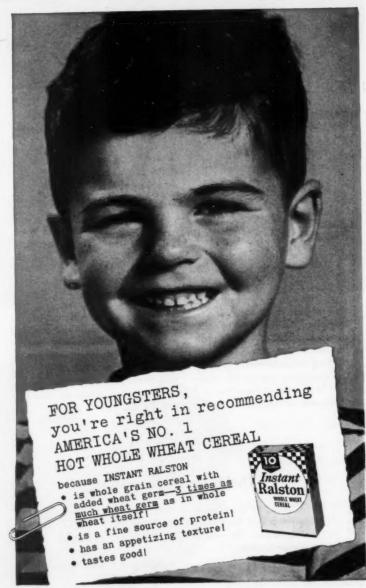
Dial G for Hypnosis

• "Would you like ether?" my husband asked, as he was about to deliver his patient's fifth baby.

"No, thanks," the woman said, "I'd just as soon listen to Arthur Godfrey."

And she did.

-JANE ANN CUNNINGHAM



How to Talk With Patients

The sure way to build good will, he maintains, is to approach the patient on his own terms

By Joseph Robinson, M.D.

• It was my Uncle Ben who set me straight. He's been in practice thirty years, and most of the people in his town get a lift the moment they step into his office. Not long ago, one of his neighbors told me: "You feel better as soon as he talks to you. Or, I should say, you feel better as soon as he listens to you."

It occurred to me that I could stand a little of that kind of word-of-mouth myself. So when Uncle Ben dropped into my office for a visit, I made a point of asking him about his patient-handling technique.

"Technique?" he snorted. "I don't have any. What makes you ask?"

"Well," I said, "take three new patients I saw this week. I had some trouble setting them at ease and getting the information I wanted from them. In fact, I had a lot of trouble. Maybe you can tell where I went wrong."

The suggestion must have roused his interest. For when I went over to my desk and got the case history cards of the three patients in question, he plucked the records out of my hand and said, "Let's see how you handled these. This man Mason, for instance. When he walked into your consultation room, what was the first thing you said to him?"

I thought a moment. "As I remember it, I said 'Good

HOW TO TALK WITH PATIENTS

morning.' Then I asked him about his chief complaint."

"Why?"

"Well, isn't that where a case history begins? Right up at the top of the card it says, 'Chief Complaint.'"

"Yes, Joe, but this isn't a case—at least not yet. It's a flesh-and-blood person. His name is Mason. Maybe he's related to some other Masons you know. Or maybe he lives in a section you're familiar with. Or maybe his line of work is one you can comment on.

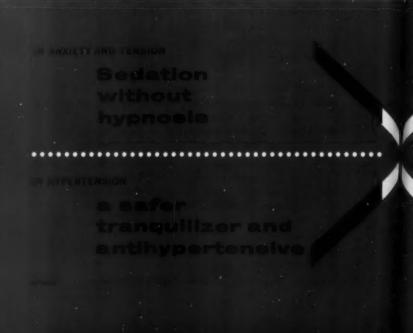
"It's an easy matter to lead into an interview with a few pleasant remarks about something like this that may be of mutual interest, and it can be counted on to help put the

patient at ease. What's more, it will make him think of you as a warm, friendly human being rather than as just another cold professional fish."

"But this man has dizzy spells, Uncle Ben. Do you think he really wants to waste time on small talk?"

Interest in Patients

"What he really wants, Joe, is to have his doctor take a personal interest in him. And small talk is one of the best ways of demonstrating such interest. Remember this: Once you find out interesting things about your patient, you automatically get interested in him—not just in his medical record."



"Okay. Maybe I do start my consultations too abruptly. But sooner or later, you've got to get around to that chief complaint. And small talk doesn't help then."

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get his "No, it doesn't. But the way you word your questions about that complaint can help a great deal . . . What was the first thing you asked this man Mason?"

"Well, I said, 'What seems to be your trouble, Mr. Mason?'

Uncle Ben laughed. "You're lucky he didn't reply, "That's for you to find out!' "

I'd heard that gag before. But I hadn't realized how I'd been inviting it in my own practice.

"You can usually avoid that sort

of answer," said my uncle, "by changing your lead-off question to What can I do for you?"... Now, how did you find out about Mason's dizzy spells?"

I replied that "He told me he was bothered by high blood pressure. But this didn't indicate his chief complaint. So I asked him how he knew he had high blood pressure. He said another doctor had told him. I finally got off that merry-goround when he volunteered the information that he'd gone to the previous doctor because he'd been having dizzy spells.

"Everything went along all right then for a few questions—until I had a diagnostic inspiration. He was a



HOW TO TALK WITH PATIENTS

ruddy-complexioned man, and I thought of a possible alcoholic factor. So I asked him whether he drank a good deal."

"And he resented it?"

"Yes. He flushed and asked, Why? Do I look like a souse?' Then I flushed and beat a hasty retreat ... Still, I think the question was a fair one."

Drink, Sex, and V.D.

"It was," Uncle Ben admitted.
"But there are three sets of questions you have to approach from the flank: alcohol, sex habits, and veneral disease. For instance:

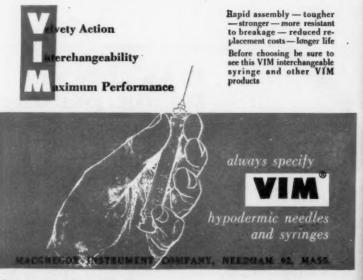
"It never embarrasses anyone if you ask how much coffee he drinks. After that, it seems natural to ask about alcohol.

"You can sound a person out on venereal disease the same way. With gonorrhea, the approach can be: sleeping habits first, then whether he gets up at night to urinate, then whether it burns.

"As for the possibility of a syphilis history, I always ask first about premarital or pre-employment blood tests."

"Well," I continued, "after examining Mason, I started to write a prescription for phenobarbital. I explained it was a strong drug that would . . . "

"Hold everything, Joe. You don't use the word 'drug' in talking to pa-



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Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity. The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal thythm and blunted defecation reflex.



JHE CHAS. H. PHILLIPS CO. DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

MEDICAL ECONOMICS MAY 1955 257

HOW TO TALK WITH PATIENTS

tients. At least I don't. A drug, to the layman, is a habit-forming narcotic. Instead, you give him a pill, a tablet, some medicine—or, if you want to sound fancy, some medication. But a drug, never."

"Maybe you're right. He did ask me if I was giving him some dope. I assured him it wasn't anything like that. I said it would calm him down and lower his blood pressure. But he seemed to resent that, too."

"I think I know why. The phrase 'calm down' is apt to connote a topblowing episode. It's better simply to explain that the tablet will take the edge off any nervousness he may have. That choice of wording would not be entirely acceptable to a pharmacologist, but it's comforting to the patient."

At this point, Uncle Ben picked up the case history card of the second new patient. Some detail evidently caught his eye; because he said, "This little girl's head injury —how did you explain it to her mother?"

"Funny thing, there. I told the mother she had no reason to worry—that it was just a mild concussion. But she was all for calling in a brain specialist. Just for a mild concussion!"

"It's not so surprising," said Uncle Ben. "While to us a 'concussion' suggests a period of interrupted consciousness then a complete res-

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PREDNISONE, (metacortandracin)

more potent than cortisone or hydrocortisone devoid of major undesirable side effects

toration of function, to the patient a concussion conjures up images of punch-drunk fighters or even threatened insanity. Many laymen actually think a concussion of the brain is the same as a fracture of the skull. So better save that word for reports to insurance companies and just tell the patient he was shaken up a bit."

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"And what if he does have a fractured skull?"

"Even more reason for not alarming him. I usually say something like 'There's a small crack in the cranium, but it will heal. Fortunately the brain wasn't touched. It escaped damage completely."

By now, Uncle Ben was reading

the record of my third new patient—the one I'd found hardest to handle of all. "You don't even have to look at the case history," I said. "It's a common situation: The patient needs a major operation but won't consent to it. I simply couldn't sell him on the idea. Any suggestion?"

Flattery, Anticipation

"About the only thing you can do," he replied slowly, "is to fall back on two of the best-known principles of salesmanship: Flatter the person's intelligence and anticipate his objections. Something like this:

"I could promise you, Mr. Brown, that the prescription I've given you will work a miracle. I



METICORTEN, brand of prednisone

HOW TO TALK WITH PATIENTS

could tell you to go home and stop worrying. But you're too intelligent to believe it. So I'll lay my cards on the table and say frankly that, while this prescription will help you temporarily, an operation is your only hope for permanent relief.'"

"Sounds like a good approach," I said as Uncle Ben reached for his hat. "I'll give it a try."

Proper Attitude

At the door, he thought of something else. "You asked me about my 'technique,'" he said. "I don't know as I'd call it that; but there is one basic rule: Getting along with patients depends on approaching them in the right frame of mind. "Even a raised eyebrow may mean, 'I'm a busy man—make it snappy.' Or 'Do you mean to say you stayed home from work just because of this?' The only safeguard is not to think such thoughts.

"Work on the assumption that the patient is sincere, that his troubles are genuine, that he came to you for personal aid and comfort. If you consistently make this assumption, it'll become second nature to you. Patients will then feel that you're on their side and they'll warm up to you accordingly."

As I shook Uncle Ben's hand and thanked him, I realized that he'd been giving me a first-rate demonstration of exactly what he meant.

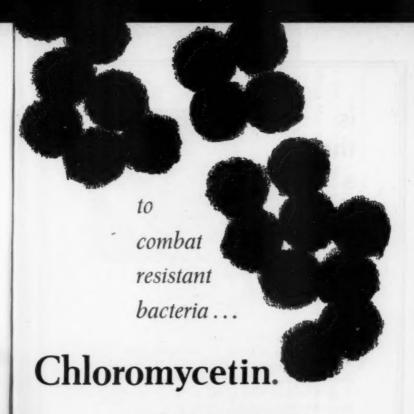
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260 MEDICAL ECONOMICS - MAY 1955





The rising incidence of bacterial resistance to various antibiotics constitutes a serious therapeutic problem. Many infections, once readily controlled, are now proving difficult to combat. Administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis) is often useful in these cases because this notable, broad-spectrum antibiotic is frequently effective where other antibiotics fail.

"... An advantage of CHLOROMYCETIN appears to be its relatively low tendency to induce sensitization in the host or resistance among potential pathogens under clinical conditions."*

CHLOROMYCETIN is a potent therapeutic-agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. 12:145, 1954.



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is there a doctor in the house



THERE certainly is in our house.

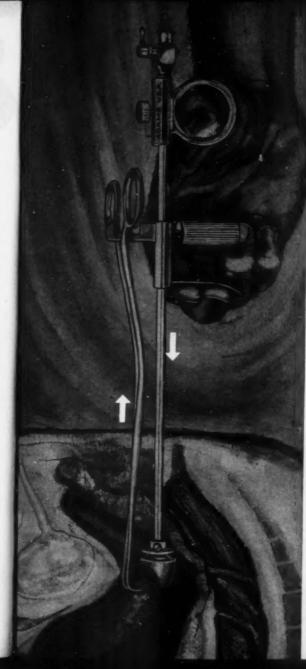
Where there is activity against cancer, there is the doctor who contributes long hours to needy cancer patients in clinics, in hospitals, in homes. It is your office of which we boast when we say "every doctor's office is a cancer detection center."

Hundreds of your colleagues, as directors of the American Cancer Society nationally, in Divisions, and with Units, bring the best medical thought to our attack on cancer by education, by research, and by service to patients.

The occasion for this brief salute is the tenth anniversary of the reorganization of the American Cancer Society and the launching of the post-war attack on cancer. Much has been achieved—far more remains to be done. We count heavily on the doctor in our house.

American Cancer Society





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How to Cope With Criticism

[CONTINUED FROM 143]

caused him far more trouble than it was worth.

And this, it seems to me, carries a lesson for all of us:

Our job as physicians is to satisfy patients. The evidence is that we do satisfy the great majority. So why press the dissatisfied few for payment? The cost of collecting such bills may be high—and I'm not thinking only of bad public relations.

An Expensive Suit

Suppose I take out a man's kidney and bill him for \$300. Suppose he's dissatisfied with my services and declines to pay. To collect via the courts might easily cost me \$100 in legal fees, plus another \$100 in wasted time.

So, instead, I simply say to the man: "Well, what do you think my services are worth?" Whatever figure he names is apt to be more than I'd get otherwise. It's worth more to me, in any case, than shattered goodwill.

I think that most physicians handle such cases in just this way; also, that those who don't may be stirring up unnecessary trouble for themselves.

How, then, can our profession cope with public criticism? My suggestions amount to this: ¶ We can do our best to satisfy each individual patient. And when we fail—as we must sometimes—we can be wary about taking our failures to court.

¶ We can let local people know about our grievance committees —not just once, but repeatedly throughout the year. Each announcement of their availability softens general criticism of our profession.

¶ We can support our grievance committees when they rule against doctors—which happens slightly less than half the time. Sometimes it's painful. But it's the truest test of whether we really deserve public confidence.

If, individually and collectively, we can attend to these things, no future officer of the A.M.A. will ever get a thousand complaints about doctors. Nor, incidentally, will any Congressman!



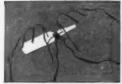
MEDICAL ECONOMICS - MAY 1955 2



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"BEND!"

"SNAP!"







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Many producers of parenteral solutions are already using Kimble Color-Break Ampuls. You can recognize them by the distinctive blue band around the neck of the ampul.

*Color-Break is a trade mark of the Kimble Glass Company, subsidiary of Owens-Illinois.

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268 MEDICAL ECONOMICS - MAY 1955

Competition In Medical Practice

[CONTINUED FROM 139]

But class differences also show up in how often a man is sick, what attitude he has toward health, how he adjusts to his physician, and how he contributes to the pattern of professional competition.

This is the way Koos breaks down Regionville's social groups:

Three Classes

¶ The upper crust includes professional and business men and their families. Most of them own their own homes, have new cars, healthy bank accounts, and ample insurance. More than half went to college.

¶ The middle group is made up of white-collar workers and steady employes. If they own a house, it's likely to be fairly heavily mortgaged. If they have a car, it's probably second-hand or at least several years old. Their savings are pretty slim, though many of them do own a life insurance policy. More than half graduated from high school.

The lower class comprises mostly laborers. They are irregularly employed and periodically on relief. They rent their lodgings, move around a lot, and have no savings or insurance. Most of them finished tenth grade, though some barely got through primary school.

The upper and middle groups,

says Koos, don't have many disabling illnesses-anyway, not for long. They're quicker to go to a doctor, don't grumble much about fees, are generally loyal to their family physician, and are likely to stick out the treatment period. Most of them wouldn't be found dead in a chiropractor's office.

These people go generally to Dr. V, Dr. W, or Dr. X. They chose their present physician for a reason that stands out above all others: The doctor had been recommended by a friend or relative.

This basis of choice, says Koos, is significant: It shows that laymen evaluate a medical man on the basis of his capacity to satisfy other laymen-often regardless of his true ability, certification, equipment, or social charm.

Picking an M.D.

What patients want, Koos found, is "psychological satisfaction." They may ignore even the fact that a doctor's treatment has been ineffective.

"Every individual," says Koos, "has conscious expectations from his treatment; but he also has certain unconscious expectations that may be even more important. If his contacts with the doctor . . . give him a sense of security, of being important, of having something done to (or for) him, and if he has the chance to unburden himself fully of his concerns regarding his health, his perception of the worth of his treatment is great. If these are lack-

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COMPETITION

ing . . . he becomes 'a press agent in reverse.' "

Koos cites as an extreme instance of this satisfaction a patient loyal to the town chiropractor even though she admits his lack of results:

"[His] treatment didn't change my condition . . . But at least he treated me right and came to the house to see me . . . Maybe nothing could be done right then for my condition. But at least he tried . . . "

A big help in giving patients that "satisfied feeling" is the family-adviser tradition that still lives on in Regionville. Koos found that 64 per cent of the families there have a family physician; and in many cases he's the same doctor who cared for their parents.

Availability Counts

Regionville's upper-class and middle-class patients usually pick a doctor, then, because he is recommended by a friend. And they stay with him because he gives psychological satisfaction.

But they are not unswayed by other factors: They put a good deal of stock, for example, in "good medicine" and "modern methods"; and in the case of Dr. W, they're attracted also by the fact that he "makes house calls" and is "indulgent about payments."

Drs. V and W are described as "sociable." One fifth of the surveyed families who regularly consult Dr. V, and one-tenth of those who go to Dr. W, say they chose these men



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MEDICAL ECONOMICS · MAY 1955 271

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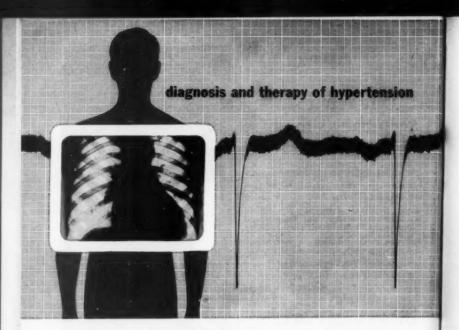
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left ventricular hypertrophy

In the diagnosis of hypertension, left ventricular hypertrophy can be recognized by two commonly used devices: the fluoroscope for direct visualization of the enlargement and the electrocardiograph for tracings, deviations in which indicate the pathology.

In the therapy of hypertension, two agents may be used for better control and greater safety. Methium with Reserpine combines the potent ganglionic blocking action of hexamethonium with the mild hypotensive and sedative effects of reserpine. Synergism between these two agents permits effective blood pressure reduction "with less than half of the usual dosage requirements for Methium."1 "...the combination appeared to be

at lower levels with less fluctuation."2 Because of the potency of Methium, careful use is, nevertheless, required. Caution is indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication. Supplied: Methium 125 with Reservine -scored tablets containing 125 mg. of Methium and 0.125 mg, of reservine,

of practical value in that, with fewer

side-effects, the blood pressure was held

tablets containing 250 mg. of Methium and 0.125 mg. of reserpine. Crawley, C. J.; Silvis, G. M.; Stumpe, W. M., and White, L.: New York State J. Med. 54:2205 (Aug. 1) 1954.
 Doyle, A. E., and Smirk, F. H.: Lancet 1:1096 (May 29) 1954.

Methium 250 with Reserpine - scored

ium with Reserpine

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"a perfect match"

WARNER-CHILCOTT

as a result of knowing them socially.

Lower-crust people are less keen about Dr. V; and they consider Dr. X too "big-wordish."

The Disenchanted

Koos' findings suggest, then, that each physician has a following of patients who find him psychologically compatible. Until that compatibility wears thin, they stay with him—no matter what allure his competitors have.

The biggest threat posed by "other doctors" is that they give disgruntled patients somewhere else to go. And from what Koos can see, Regionville has its share of the disgruntled. For instance:

¶ Forty-four per cent of those interviewed were either outspokenly critical of their medical care or unwilling to say they were satisfied with it.

¶ Fourteen per cent of those who reported having a family doctor said they'd switched to him out of resentment toward a previous one.

¶ Twenty-five per cent of the disabling illnesses reported were not under the care of any M.D.

¶ Of every ten patients treated during the period under study, one had initially consulted the local chiropractor instead of a physician; one had gone to an M.D., soured on him, and then wound up with the chiropractor; one had started treatment with an M.D. but quit before treatment was completed.

¶ A few families ignored local

doctors and went to the city-sixty miles away-for medical care.

¶ Ten per cent of hospitalized patients likewise chose out-of-town doctors.

How do Regionville M.D.s react to such fault-finding? Like squirrels, Koos shows: Each counters the threatened loss of patients by hoarding those he can. Each pursues his professional activities in squirrelcage isolation from his colleagues.

Public discontent is the culture medium in which the virus of medical competition flourishes, the Regionville study suggests. And here's how local physicians meet such competition:

They avoid making referrals. Of 1,634 cases of illness reported, only two were referred to other physicians. Says one patient: "These boys never send you to another doctor. They're afraid of losing business."

They pass up opportunities for refresher training. Free clinical teaching programs of high caliber, offered by an accessible metropolitan hospital, have never yet enrolled a Regionville physician. One M.D. allegedly gave this reason: "The other doctors would steal my patients while I was gone."

Jealousy over publicity hamstrings their public relations. A Regionville organization planning a discussion of cancer couldn't induce one local doctor to appear as a speaker. Refusals assumed various disguises: "Medical ethics wouldn't allow me . . . " or "This would put



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me in a bad spot with my competitors."

They hurry their patients. Dr Z, with his small practice, is an exception. But the other M.D.s, jumpy with "competition nerves," feel that they must see as many patients in a day as they possibly can. So they rush them through their offices like parts on an assembly line, belittle their woes to shut them up, and skimp on explanations. Result: Patient relations are so brittle that they break under the slightest pique. Koos recorded such mutterings as these:

The doctor was "brusque."

He was "evasive."

He was "unsympathetic" or "uninterested in the case."

(One of the main reasons Regionville people give for resorting to the chiropractor is that "he takes more time with you." A woman patient adds that "he don't act as though there was nothing wrong with you the way I could name some doctors who do . . . ")

The M.D.'s Side

Meanwhile, the competition-torn Regionville M.D. states one of his

complaints:

"Practicing medicine here would be fine if it weren't for the damned neurotics. I'd guess that 25 per cent of the patients I see—mostly women —haven't got a thing wrong with them that a good day's work wouldn't cure."

But how did rivalry among Re-

gionville's doctors become so acute? The Koos report explodes three popular fallacies on the subject:

1. The fallacy that competition is due to "too many doctors."

Regionville, says Koos, is "not conspicuously overstaffed." In fact, it has more people per physician (1,200) than does the state as a whole (700).

The fallacy that competition is due to financial or social insecurity.

Regionville's doctors are among the town's leading citizens. They appear to be well-off and respected. They have "nice offices and big automobiles."

 The fallacy that competition is sparked by someone who takes unfair advantage of his colleagues.

Koos describes none of the town's physicians as a Pied Piper or a publicity hound. None conducts sneak attacks on his colleagues or uses unseemly practice-building techniques. None, in short, resort to methods a medical society could actually censure.

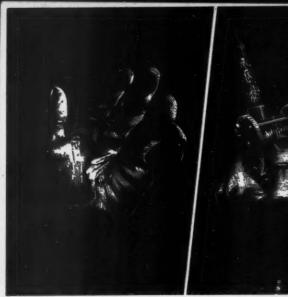
Yet the rat race is on.

Koos thinks he knows some of the reasons why Drs. Y and Z are the main victims of professional rivalry in Regionville and why even the physicians who are successful there are losing some of their best patients:

They don't keep up to date.

They're unsympathetic to the patient's fears.

They don't relieve tension over fees. [MORE >





from rigidity to relaxation

When the rigidity and pain of arthritis and related rheumatoid disorders prevent the patient from enjoying a normal, satisfying life, Acetycol may open a road to rehabilitation. Therapy with Acetycol provides welcome relief of pain and increases the range of painfree movement. Thus the patient is able to resume more normal activities in his work and relaxation.

The effectiveness of Acetycol is based on synergism between aspirin and paraaminobenzoic acid. The combination of these two agents produces high salicylate blood levels on relatively low dosages. Salicylated colchicine extends the effectiveness to cases of a gouty nature.

Acetycol also contains three essential vitamins often lacking in older patients: ascorbic acid, to prevent degenerative changes in connective tissue; thiamine and niacin, for carbohydrate utilization and relief of joint pain and edema.

Usual dosage-1 or 2 tablets three or four times a day.

Each Acetycol tablet contains:

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Aspirin	325.0 mg.
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Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
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Supplied: Bottles of 100 and 500.

Acetycol

to relieve rheumatic pain

WARNER-CHILCOTT

COMPETITION IN MEDICAL PRACTICE

They fail to talk the patient's language.

They've done nothing about getting their hospital accredited.

Failing to keep up-to-date seems to be the crucial issue. "We had Dr. Z for a long time," says one patient, "but we had to give him up last year . . . He was still handing out the same old . . . pills."

The charge of being behind the times is leveled most often at Drs. Y and Z, Koos notices, even though patients appreciate their being "easy to get along with." But he finds that

even the other practitioners are at least one step behind, in their apparent ignorance of psychosomatic medicine, and are taking few precautions to escape discard in the future.

One patient explains why her family goes to a physician sixty miles away from Regionville, in the city: "We could get our care cheaper here, counting the trip and all; and sometimes it's hard to find the money to pay [the city doctor] ... But we have more faith in himhe's on the medical school [hospital



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COMPETITION

staff] and is up-to-date in his medi-

Another way M.D.s alienate patients, says Koos, is to forget that what motivates more than half of them is not necessarily illness but fear of illness. To dismiss an overanxious patient without allaying his fears, he implies, is to risk his consulting someone else. One out of every five people interviewed who'd dropped an M.D. and resorted to seeing the local chiropractor charged that "the physician said nothing was wrong."

The Old Brush-Off

Koos quotes a woman patient who was infuriated by this attitude: "Twice I called Dr. V," she said, "when I felt real bad—or thought I did—and both times he pooh-poohed my complaints and said there was nothing wrong with me . . . I don't know how you're supposed to know when to call a doctor, when he acts that way."

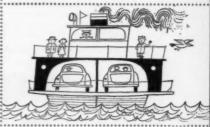
"An undercurrent of economic tension" is yet another hazard to Regionville physicians in keeping their patients satisfied. Researchers found "expenditures for medical care... the most difficult of all subjects discussed." They learned that concern about costs keeps some people from seeking medical treatment, others from completing treatment, and many more from being content with treatment.

Failure to discuss the case straightforwardly—what Koos calls a "lack













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MEDICAL ECONOMICS - MAY 1955 283

of communication"—seems to be especially troublesome. "Maybe things would be better," one patient remarked, "if the doc understood us and if we knew what the hell he was driving at."

In this connection, Koos quotes a discouraged patient who refused to return for further treatment because the physician "didn't help me one bit." The treatment might have been salvaged, Koos intimates, if the doctor had only taken the trouble to explain it. This very lack of communication, he believes, is often what makes the patient think the doctor is incompetent.

Financial and other grievances are also the result of poor communication, Koos says. He points out that complaints of "unnecessary hospitalization" and "prolonged treatment," for example, are based entirely on lay judgments. A convincing explanation might well cause them to evaporate.

Derelict in Duty

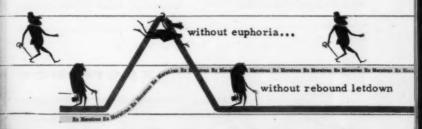
But Regionville physicians can't talk their way out of criticism about serving on the staff of an unaccredited hospital, Koos finds. Many local patients who need hospital care either do without it or go to out-of-town institutions. Responsibility for getting the Regionville hospital accredited lies clearly with the doctors themselves, says Koos, and they have defaulted: "The inadequacy of a hospital results . . . from the willingness of the physician to work

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COMPETITION IN MEDICAL PRACTICE

under substandard conditions . . . "

Koos adds that Regionville does "not appear to be" too poor to support an adequate hospital.

Lay Misconceptions

A Regionville physician, trying to meet competition, finds himself going around in a circle: He can hold his own only with the support of satisfied patients. But the patient's satisfaction may depend on uninformed notions and unconscious desires, rather than on intelligent evaluation of medical advice. So the doctor's success, Koos observes, is "at the mercy of the layman's perception of what he needs and of what the doctor has to offer."

Understandably, then, Koos feels the physician can help himself by helping to enlighten the public. "One of the ideal roles of the physician is that of teacher," Koos declares. To "help the patient understand the workings of illness," he says, is a matter of tremendous mutual advantage.

The lack of health information in Regionville shows up clearly in the Koos study: People were asked which of twenty symptoms they considered worth a visit to a medical adviser. The answers varied sharply according to the social class of the person replying:

Substantial percentages of the lower class failed to see anything

the handwriting on the wall...

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ominous in shortness of breath, swelling of the ankles, a lump in the abdomen, or excessive bleeding. Even in the better-educated upper crust, one out of every five expressed little or no concern about chronic fatigue, weight loss, persistent headaches, fainting spells, or chest pain.

Happily, sociologist Koos sees a way out for Regionville's rivalryridden physicians. This is what he recommends:

¶ Work more closely with colleagues, understanding them as members of "the medical team."

¶ Keep up with medical advances and broaden your understanding of the social and psychological implications of treatment.

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¶ Promote better understanding of the physician's role in the community as a student of "man, a social and family unit."

We may conclude from the Koos study, then, that the medical man who recognizes class differences among his patients and is guided by them in his practice is the one most likely to take professional competition in his stride:

He's alert to the challenging standards of the upper crust. He's prepared for the educational deficiencies of the lower crust. And in either case he can adjust to the patient's needs and give him that psychological satisfaction from which patient loyalty stems.



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Who Should Control Practice in Hospitals?

[CONTINUED FROM 136]

the provisions of the statutes concerning the illegal practice of medicine or surgery when they employ full-time paid specialists who are licensed physicians to conduct necessary tests and perform services in the treatment of patients at the hospital."

The Connecticut opinion held that a nonprofit hospital can charge for the services of the licensed physicians it hires.

The Attorney General wrote: "No

question has ever been raised that the hospital is practicing medicine illegally because it keeps the entire charge made for these services."

Meanwhile, the Iowa State Medical Society has instructed its counsel to help prepare the defense, because the society is on record "in complete support of the specialists in the dispute."

Since the petition was filed, neither side has made a positive move to settle the dispute out of court.

Doctors who are willing to be quoted, however, believe that some settlement is still possible. One of those who feel that way is Dr. Walter D. Abbott, chairman of the

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PRACTICE IN HOSPITALS

state medical society's committee on medical practice in hospitals. For the past year he and his committee have been conferring with hospital representatives in an effort to work out a hospital contract for specialists acceptable to both sides.

Compromise Sought

"On one occasion," he says, "we came reasonably close to a settlement. Both sides submitted plans and from them the Attorney General drafted a compromise agreement. We succeeded in agreeing on all but three of seventeen points."

These three points, which are still in dispute, cover the two basic issues of control of facilities and billing. "I've always believed this controversy could be resolved at the local level," Dr. Abbott says. "I still think that is possible if both the hospitals and the specialists accept the contracts approved by the Attorney General or modifications of them, so long as these modifications remain within the law and conform with medical ethics."

Dr. Caughlan says: "A compromise can be worked out along these lines: The operation of pathology and radiology departments in hospitals would remain as it is. But new contracts would have to be drawn to conform with the law and medical ethics. Under these contracts, control of these departments and their



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294 MEDICAL ECONOMICS MAY 1955

PRACTICE IN HOSPITALS

personnel would be in the hands of the pathologist or the radiologist.

"The specialist's bill for services would have to show what percentage of the laboratory charge would be paid to the hospital and what percentage to the pathologist or radiologist. This would eliminate the suspicion that these specialists are captive employes of the hospital and would satisfy the law."

Hospital spokesmen have no comment on this other than to refer to their lawsuit.

Limited Compromise

One limited compromise was worked out recently in legislation to enable Iowa to accept \$2,250,000 in Federal funds for a hospital construction program that would include diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes.

The medical society at first backed state legislation which would have excluded Federal aid for diagnostic and treatment centers and for any hospital which hires physicians.

Later it learned that the Eisenhower Administration would withhold all funds if any strings were attached at the state level. So the society then joined the hospital association in approving an enabling act acceptable to both sides.

The compromise bill eliminated all reference to hospitals that hire physicians. Instead, the bill included a clause increasing from two to five



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the number of physicians on an advisory council that will study the need for additional diagnostic and treatment centers.

Public Relations

An unwelcome result of the present physician-hospital controversy has been unfavorable publicity for the medical society and specialists in newspaper editorials and letters to the editor. To combat this, the society has found it necessary to authorize a \$25 assessment per member for educational and public relations activities.

Some indication of the public relations job facing the Iowa doctors is to be found in this paragraph from a recent editorial in The Des Moines Register:

"Aside from the legal question, we think the public has yet to be convinced that the change asked by the medical specialists would result in any better medical care for patients. Despite assurances from the medical people, the ultimate result might be higher costs for the patient."

To counter criticism of this sort, Dr. Caughlan is urging every physician to address service clubs, veterans' organizations, lodges, church groups, and farm organizations.

Iluria

"It is every doctor's fight," Dr. Caughlan wrote in a recent issue of the state society's journal. "He must talk with his patients of the peril that the profession is facing. The public must be told that when medi-

cine becomes socialized, it is probable that other sections of our economy will follow."

The society is trying to woo the public with pamphlets. One entitled "Medical Practice—Free or Hospital-Controlled?" explains in question-and-answer form the Attorney General's ruling and its meaning to the public.

One question reads: "Can the doctor bill be rendered and collected by the hospitals?" The answer: "Yes, it would only require attaching the doctor's statement to the hospital bill with the hospital collecting the total amount, or the doctor could bill direct."

'An Inducement'

Another question asks: "Do you feel the changes anticipated will encourage men trained in these specialties to come to Iowa?"

The answer: "Very definitely so. The fact that the position of the radiologist and pathologist has been clarified with regard to his relationship with hospitals should induce these physicians to locate in Iowa."

What, then, is the prognosis?

Unless a compromise can be reached—and the prospects are not bright—the courts will have to decide. Whatever the decision, it will be appealed.

Right now, the physicians and the hospitals agree on only *one* thing: An appeal to the Iowa Supreme Court is going to take a long time.

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Index of Advertisers

Abbett Laboratories 28 Dayalets 28 Erythrocin 62, 6 Iberol 292, 29 Tronothane 17	Central Pharmacal Company, The Neocylate with Cortisone
Erythrocin 62, 6	Ciba Pharmaceutical Products, Inc.
Iberol	Antrenyl-Phenobarbital
Tronothane 17	Doriden 14, 86, 228, 2
Aeroplast Corporation Aeroplast	Purihangamina 900 9
Aeroplast 1	Serpasil
American Bakers Association	Serpasil-Apresoline 48,
Enriched Bread 20	Serpasil Elixir88,
American Cancer Society26	Clay, Adams Company Inc
American Cyanamid Company	Kahn Uterine Trigger Cannula
Folic Acid 18	Colwell Publishing Co.
Folic Acid 18 Triple Sulfas 6	Colwell Publishing Co. The Daily Log
American Cystoscope Makers, Inc.	Cutter Laboratories Polysal
A.C.M.I. Hemostatic Bag Catheters 31	Polysal
American Hospital Supply Corp.	
Twiniday	
A C I	Desitin Chemical Company
Ames Company, Inc. Clinitest 20	Desitin Ointment 2
Decholin & Decholin Sodium 6	Dictaphone Corporation
Armour Laboratories	Time-master
Armatinic 210	
HP Acthar Gel 4	
Nidar 270	
Nidar 270 Tri-Synar 172	
Avnor-Stone Laboratories Inc	Eastman Rodak Company
Americaine Aerosol 210	Kodascope Pageant Sound Projectors
Ascher & Company, Inc., B.F. Convertin	150, 1
Convertin 21	Eaton Laboratories Furadantin
Amend Laboratories	Edin Company Inc.
Ayerst Laboratories Beminal 230	Model 250 Electrocardiograph
Premarin 288	Elbon Laboratories, Inc.
Premarin with Methyltestosterone	Co-Nib
	Electro-Physical Laboratories Inc.
	Candistney DC 9
Bettle & Company	
Battle & Company Bromidia	
Bauer & Black (Div. of Kendall Co.)	Fleet Company, Inc., C. B.
Tensor Elastic Bandage	DL L - C (WI A)
Baxter Laboratories Trinidex	21.02
	Geigy Chemical Co. Eurax
Bayer Company, The	Eurax
Children's Size Aspirin 266	General Foods Corp. Sanka Coffee
Becton, Dickinson & Company	Sanka Collee
Ace Bandage 21	Gomeo Surgical Mfg. Corp. Explosion-Proof Suction Units
Belmont Laboratories Co.	Explosion-Proof Suction Units
Mazon Dusi Therapy 34. 35	Green Shoe Mfg. Co. The StrideRite Firstie
Borcherdt Malt Extract Co. Malt Soup Extract	The StrideRite Firstie
Malt Soup Extract 85	
Bristol Laboratories, Inc.	Wandless Mr. Commen
PolycyclineInsert between 256, 257	Examining Room Equipment
Burroughs Walleama & Co	Heinz Company H. I.
Antepar 170	Heinz Company, H. J. Baby Foods
Marezine	Hoffmann-LaRoche, Inc.
Burton Manufacturing Co. Manotest	Hoffmann-LaRoche, Inc. Gantrisin Cream 20 Noludar "Roche" Insert between 32, 3
Manotest 294	Noludar "Roche" Insert between 32. 2
In Specified Territories	IMOREA

INDEX OF ADVERTISERS

International Cellucotton Products Co. Professional Kleenex
Professional Kleenex 3 Irwin, Neisler & Company 176 17
Obocell
Unitensen
Jackson-Mitchell Pharmaceuticals, Inc.
Meyenberg Goat Milk
Band Aid Plastic Strips ?
Sterile Gause Pads29
Kidde Manufacturing Co.
Tubal Insufflator 7
Kimble Glass Company Color-Break Ampuls 26
Color-Break Ampuls
Kinney & Company Emetrol 3
Knox Gelatine Co., Inc., Chas. B.
Knox Protein Previews20
Kremers-Urban Company
Phyatromine-H & Salimeph-C Tablets
Lakeside Laboratories, Inc.
Piptal Insert Between 96,9
Lavoris Company, The
Lavoris 29
Lederle Laboratories
Achromycin SF
Aureomycin
Gevral 2 Gravidox 20
Gravidox 20 Pathilon 182, 18
Prenatal Capsules17
Stresscaps 1
Lilly & Company
Co-Pyronil 42, 4 Sandril 64, 28
Sandrii
Lleyd Brothers, Inc. Roncovite 92, 9
Lorillard Company, P.
Kent Cigarettes 22
M & R Laboratories
Similac218, 21
McNeil Laboratories, Inc.
Syndrox230, 23
MacGregor Instrument Company
Vim Hypodermic Needles & Syringe 25
Medical Case History Bureau Infodex 17
Medical Economics, Inc
Medicone Company
Rectal Medicone26
Mennen Company, The
Baby Powder 5
Merrell Company, The Wm. S.,
Bentyl IFO Meratran 283, 28 Nitranitol with Rauwolfia 244, 24
Nitranitol with Ranwolfia 244 24
Attrantion with Rauwoins244, 24
National Drug Company, The
AVC 21 Parensyme 76 7

Num Specialty Co. Thum	190
Ortho Pharmaceutical Corp. Ortho & Preceptin	
Insert between 10	161
Parke, Davis & Company Chloromycetin	261
Patch Company, The E. L. Kondremul Plain	30
Pelton & Crane Co., The Autoclaves	96
Pet Milk Company Evaporated Milk	271
Pfizer Laboratories Div. of Chas. Pfizer & Co. Bonamine	281
Terra-Cortril Topical Ointment	90, 91 250
Toclase	250
Phillips Co., The Chas. H.	0.50
Physicians' Desk Reference 2'	74. 275
Anatomic "Century II"	15
Pitman-Moore Company Novahistine	47
Poliomyelitis Vaccine (Salk) Procter & Gamble Co., The	232
Ivory Handy Pads Professional Printing Company, Inc.	BC
Histacount Pyramid Rubber Co.	214
Evenflo Nursers	295
Ralston-Purina Company Instant Ralston Raytheon Manufacturing Company	252
Microtherm	276
Riker Laboratories, Inc. Pentoxylon	19
Rauwiloid	84
Rauwiloid-Veriloid	301
Ritter Company Universal Table Robins Co., Inc., A. H. Donnatal Extentabs Donnalate-Robalate	27
Donnatal Extentabs	148
Donnalate-Robalate Entozyme	78 154
Pabalate	180
Roerig & Co., J. B. Roetinic	242
Viterra	82
Sanborn Company Viso-Cardiette	29
	6, 247
Schering Corporation Meticorten	8, 259 24, 225
Prophylactics	303
Scholl Mfg. Co., Inc., The Arch Supports Searle & Co., G. D.	302
Mictine	70, 71
Shampaine Company Steelux Examining Room Furniture Sharp & Dohme, Inc.	66
Remanden	IBC

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INDEX OF ADVERTISERS

Gericaps	29
Shield Laboratories Riasol	19
Smith, Kline & French Labor	
Dexamyl Spansule	16, 1
Edrisal	5
Spansule Capsule162, 163	, 164, 165, 166
Thorazine	167, 167
Trophite	
	U
Smith Co., Martin H. Expasmus	201
Spencer Industries Plexiglas Signs	286
Squibb & Sons, E. R.	
Mysteclin Insert be	tween 192, 193
Strasenburgh Co., R. J.	
Maxitate with Rauwolfia	198
Stuart Company, Inc., The,	100 100
Theron	178, 190
Tampax Incorporated	-
Tampax	248
United States Brewers Founda	tion
Diet Facts	3:
U.S. Vitamin Corporation Methischol	222, 223
Upjohn Company, The	
Pamine Tablets	
Upjohn Company, The Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table	56 r 226
Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table	56 r 226
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc.	56 r 226
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment	r 226 ets 66
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H.	r 226 ets 66
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide	r 220 sts 69 69 69 69 69 69 69 69 69 69 69 69 69
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene	r 220 r 220 ets 66 enry K., 286, 287 234, 235
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene	r 220 ts 66 66 66 66 66 66 66 66 66 66 66 66 66
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral	r 22cts 66
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol	r 224 sts 66 enry K., 286, 287 234, 236 41 55
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusii	r 224 enry K., 286, 287 234, 235 41 55
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine	56 234 235 235 235 235 235 235 235 235 235 235
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate	r 221 rts 6t enry K., 286, 287 234, 234 55 277 41 55 277
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Tedral Web Truss Company	51 224 254 254 254 254 254 255 255 255 255
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusii Methium Peritrate Tedral	51 224 254 254 254 254 254 255 255 255 255
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc.	56 234, 236 276 41 55 234 236 277 67 302
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Inc. Rectal Instruments	56 234, 236 276 41 55 234 236 277 67 302
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc.	56 234, 235 278 66 191 302 32
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum	5 tr 224 ts 6t 6t 6t 7 ts 6t 7 ts 6t 8t
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Acusol Gelusil Methium with Reserpine Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan	55 r 224 fs 66 fs 286 287 234 236 237 66 297 302 32 32 55 9 55 9 55 9 5 9 5 9 5 9 5 9 5 9 5 9
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan BisoDol	5 r 224 r 224 sts 66 enry K. 286, 287 234, 235 234, 235 239 241 55 239 302 32 32 40 158, 159
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan BiSoDol Whittier Laboratories	56 c 234 c 255 c 256 c 2
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan BiSoDol Whittier Laboratories Ertron & M-Minus 5	56 c 234 c 255 c 256 c 2
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan BiSoDol Whittier Laboratories Ertron & M-Minus 5	5 r 22t
Pamine Tablets Pamine-Phenobarbital Elixi Pamine-Phenobarbital Elixi Pamine-Phenobarbital Table Walker Laboratories, Inc. Bacimycin Ointment Wampole & Company, Inc., H. Artamide Verapene Warner-Chilcott Laboratories Acetycol Agoral Anusol Gelusil Methium with Reserpine Peritrate Tedral Web Truss Company Web Truss Welch Allyn, Inc. Rectal Instruments White Laboratories, Inc. Aspergum Lactofort Whitehall Pharmacal Compan BiSoDol Whittier Laboratories Ertron & M-Minus 5 Winthrop-Stearns, Inc.	56 234, 235 234, 235 234, 235 253, 253 260 260 261 261 261 262 263 263 264 264 265 265 265 265 265 265 265 265

^{IN} CONCEPTION

prescription to fit the patient

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68 73 51

05

80

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48

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56 26

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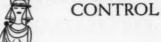
96

one method of conception control is applicable to all patients. For some, the "diaphragm-andjelly" technic serves best, for others "jellyalone" is adequate. Responsibility for selecting the more desirable method rests with the physician, who often considers the patient's preference.

From the physician's point of view: When life and health depend upon prevention of pregnancy, the diaphragm-jelly method becomes first choice. If certain anatomic difficulties exist such as relaxed pelvic floor,1,2 extensive cystocele,1-3 extensive rectocele,1-3 intact hymen,3 short anterior vaginal wall,2 third degree retroversion of the uterus,3 acute anteflexion of the uterus2 or complete prolapse,2 proper placement of the diaphragm usually is not feasible. Safer than jelly applied to an improperly fitting diaphragm is jelly-alone inserted into the vagina. Inability to learn the diaphragm technic also necessitates jelly-alone.

From the patient's point of view: The highly fertile multiparous patient who considers her family complete will seek the extra protection of a diaphragm. Women motivated by a morbid fear of pregnancy will prefer to reduce the risk of conception by using both a mechanical device and a spermaticide. Conversely, if there is no urgent need to avoid conception, 4,8 jellyalone will be the choice because of its simplicity.

Dependability of each technic: Diaphragm-and-jelly offers the most depend-



able conception control, 1,2,6-8 with reliability of 95% to 98%. 6.7 Jelly-alone will provide a high degree of protection in nonparous women and in women of low parity.4 Among 325 women who used

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After the decision has been made: When the choice favors diaphragm-and-jelly, the RAMSES® "TUK-A-WAY" kit is recommended. The RAMSES diaphragm, flexible and cushioned, provides optimum mechanical barrier with utmost comfort. With RAMSES Jelly,* it offers an unsurpassed contraception technic. Where jelly-alone is indicated RAMSES Vaginal Jelly can be confidently prescribed. Both products are accepted by the appropriate Councils of the American Medical Association.

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Memo

FROM THE PUBLISHER

Special Projects

In this issue, we've taken the wraps off another of our major research projects: a comprehensive study of malpractice insurance. It's been in the works for almost a year.

"I wish I'd known you were preparing such an article," one physician wrote us after seeing advance proofs. "I wouldn't have switched malpractice policies when I did."

That made us wonder: Should we say something occasionally about the major articles we've got coming up? It might prove of some help, even though titles are still tentative and completion dates uncertain. So here's a sampling:

¶ "Letter to Your Widow." When a doctor dies, his surviving spouse faces practice-connected problems she's unprepared for. This article is an attempt to prepare her—a report on the lessons others have learned through sad experience. Both you and your wife should profit from it.

f "Texas Medicine"—the facts vs. the legends. We've just surveyed 500 Texas physicians to find out in what respects medical practice is different there. Our past "regional profiles" have ranged from Park Avenue practice to mining-town

medicine. But our Texas round-up may turn out to be the biggest, the most colorful—well, the most typically Texan profile of all.

"Does a Technician Pay Off?"
Many doctors have asked us this question—whether it's economically feasible to install their own laboratory facilities, plus the personnel to run them. We, in turn, have been asking doctors who've done it. Their stories should soon be ready to tell.

¶ "The Doctor's Health." How many days did you lose last year because of illness? Were you under the care of another doctor? Have you ever had the so-called "doctors' diseases"? How long ago did you last have a complete physical? Have you ever been to an osteopath? These questions, and almost a hundred others, are being put to 2,500 medical men. Results will appear as the first article of an important new series on the doctor's private life.

"Is Private Practice Doomed?" Looking ahead ten years, some men have foreseen the day when most M.D.s will work on salaries for hospitals or health plans. Is this what's likely to happen? We're interviewing and polling the most thoughtful men in medicine for their view of things to come.

All five of these special projects, by the way, were originally suggested to us by individual readers. So if you benefit from the resulting articles, perhaps that makes it *your* turn to suggest one.

-LANSING CHAPMAN

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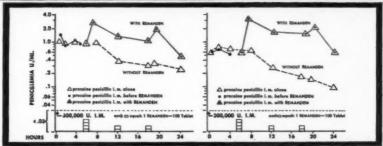
117

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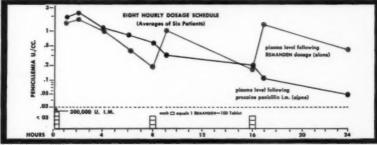
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No. 1: "Instructions for Routine Care of Acne."

No. 2: "Instructions for Bathing a Patient in Bed." No. 3: "Instructions for Bathing Your Baby."

No. 4: "The Hygiene of Pregnancy."

No. 5: "Home Care of the Bedfast Patient." No. 6: "Sick Room Precautions to Prevent the Spread of Communicable Disease."

